



USAID INTEGRATED HEALTH PROGRAM

Fiscal Year 2018 Annual Report

October 30, 2018

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Cover Photo: *Credit:* Landry Malaba, USAID Integrated Health Program (IHP)
Dr. Janvier Barhobagayana (Eastern Congo Regional Director, USAID IHP), Dr. Zozo Musafiri (*Chef de Bureau Technique Appui*, DPS), Dr. Pepin Nabugobe (*Chef de DPS*, Sud Kivu), and Dr. Jeanne Tshibungu (Sud-Kivu Provincial Director, USAID IHP) during the work planning workshop in July 2018.

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With:

International Rescue Committee
Bluesquare
Mobile Accord/Geopoll
Viamo

Pathfinder International
Training Resources Group
i+Solutions
Matchboxology

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ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
ADS	Automated Directives System
AMEP	Activity Management and Evaluation Plan
ASSP	<i>Accès Aux Soins de Santé Primaires</i>
BCZ	<i>Bureau Centrale de la Zone</i>
CADIMEK	<i>Centrale d'Administration et de Distribution des Médicaments Essentiels du Kasai</i>
CDCS	Country Development Cooperation Strategy
CLA	Collaborating, learning, and adapting
CODESA	<i>Comité de Développement de l'Aire de Santé</i>
COP	Chief of Party
COR	Contracting Officer's Representative
CORDAID	Catholic Organization for Relief and Development Aid
CRMP	Climate Risk Mitigation Plan
CSO	Community service organization
DCOP	Deputy Chief of Party
DFID	Department for International Development (of the United Kingdom)
DGOGSS	<i>Direction Générale de l'Organisation et de Gestion des Services et des Soins de Santé</i>
DHIS2	District Health Information System 2
DHS	Demographic Health Survey
DNH	Do No Harm
DPS	<i>Division Provinciale de la Santé</i>
DRC	Democratic Republic of the Congo
ECHO	European Civil Protection and Humanitarian Aid Operations
ECZS	<i>Equipe Cadre de la Zone de Santé</i>
EMMP	Environment Mitigation and Monitoring Plan
EMMR	Environment Mitigation and Monitoring Report
ERF	Environmental Review Form
GDRC	Government of Democratic Republic of the Congo
GHSC-TA	Global Health Supply Chain-Technical Assistance Project
HCD	Human-centered design
HMIS	Health Management Information System
HSS	Health systems strengthening
IDP	Internally displaced people
IEE	Initial Environmental Examination
IGA	Integrated Governance Activity

IHPplus	Integrated Health Project Plus
IP	Implementing partner
IPS	<i>Inspection Provinciale de la Santé</i>
IPTp	Intermittent Preventive Treatment in Pregnancy
IR	Intermediate result
IRC	International Rescue Committee
IRS	Indoor residual spraying
LLIN	Long-lasting insecticide-treated nets
LMIS	Logistics Management Information System
M&E	Monitoring and evaluation
MCZ	<i>Médecin Chef de Zone</i>
MNCH	Maternal, neonatal, and child health
MOH	Ministry of Health (<i>Ministère de Santé</i>)
MSH	Management Sciences for Health
OCHA	Office for the Coordination of Human Affairs (of the United Nations)
PICAL	Participatory Institutional Capacity Assessment and Learning
PMI	President's Malaria Initiative
PMP	Program Management Plan
PNDS	<i>Programme National de Développement Sanitaire</i>
PNLP	<i>Programme Nationale de Lutte Contre le Paludisme</i>
PNLT	<i>Programme Nationale de la Lutte Contre La Tuberculose</i>
PRONANUT	<i>Programme National de Nutrition</i>
PROSANI USAID	<i>Projet de Santé Intégré de l'USAID</i>
RECO	<i>Relais Communautaire</i>
RME	Research, monitoring, and evaluation
SBC	Social and behavior change
SMS	Short messaging service
TB	Tuberculosis
TRG	Training Resources Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID IHP	USAID Integrated Health Program
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
ZS	<i>Zone de Santé</i>

EXECUTIVE SUMMARY

USAID's Integrated Health Program (USAID IHP) in the Democratic Republic of the Congo (DRC) is the Mission's flagship program. Its purpose is to strengthen the capacity of Congolese institutions and communities to deliver quality, integrated health services that sustainably improve the health status of the Congolese population. To achieve this purpose, USAID IHP has three objectives:

- 1) Strengthen health systems, governance, and leadership at provincial, health zone, and facility levels in target health zones
- 2) Increase access to quality integrated health services in target health zones
- 3) Increase adoption of healthy behaviors, including use of health services, in target health zones

With a seven-year implementation period (a four-year base period and three-year option period), USAID IHP has time to achieve measurable impacts in our three target regions and nine provinces: Eastern Congo (Sud-Kivu and Tanganyika); Kasai (Kasai-Central, Kasai-Oriental, Lomami, and Sankuru); and Katanga (Haut-Katanga, Haut-Lomami, and Lualaba). The Program builds on previous USAID investments in health in the DRC, as well as on USAID's Country Development Cooperation Strategy (CDCS) and related Government of the DRC (GDRC) strategies and policies.

Our key DRC beneficiaries and partners are the Ministry of Health (MOH), *Comités de Développement de l'Aire de Santé* (CODESAs), community health workers, and community members. The MOH at the central level is our day-to-day counterpart institution; our relationships with the ministry will provide access to national-level expertise in domains pertinent to the Program and will ensure we are full aligned with national policies, strategies, and plans.

USAID IHP seeks to leverage the potential of decentralization and accelerate reductions in maternal, newborn, and child deaths. The Program supports the MOH in tackling challenges identified in the *Plan National de Développement Sanitaire* (PNDS 2016–2020 and the reframed PNDS 2019–2022). These include poor-quality service delivery and insufficient infrastructure, equipment, human resources, commodity supplies, health financing, health information use, and governance.

Our Program design is strongly inspired by the widely used health systems strengthening framework in which health system pillars are the prominent concepts. However, because our funding streams derive from key health services areas, we must also achieve programmatic goals essential to these areas. We are therefore supporting provincial health systems to empower their health zones (*Zones de Santé*, or ZSs) to sustainably deliver quality services in malaria; maternal, neonatal, and child health (MNCH); nutrition; reproductive health and family planning; tuberculosis; and water, sanitation, and hygiene (WASH). Program activities also address cross-cutting concerns such as gender equity, conflict sensitivity, capacity building, private sector development, and climate risk and environmental mitigation.

Abt Associates was awarded the USAID IHP contract on January 31, 2018. We received a stop-work order on February 15, 2018, due to a protest. When the stop-work order was lifted on May 26, 2018, we immediately mobilized for start-up. This report describes activities during the period from May 29, 2018, through the end of the U.S. government's fiscal year on September 30, 2018—a period of approximately four months.

Once operations recommenced, we engaged in intensive operational and technical start-up to mobilize our team and prepare for joint planning with the USAID Mission, the MOH, and key personnel and other advisors already on board. For reasons of protocol, the customary formal introductions to the USAID Mission and the MOH could not be synchronized with a work planning workshop that was already in advanced stages of preparation.

In consultation with the USAID Contracting Officer's Representative, we proceeded with the July 23–27, 2018, workshop so that we could create a work plan without further delay. All subcontractors participated, many with U.S.-based leadership and all with representative DRC-based staff. At this key planning event, the USAID IHP team developed a joint understanding of the Program's mission, objectives, and planned results. We also formed promising relationships with the Kinshasa School of Public Health and with several USAID-funded partners with whom we will collaborate to pursue the goals of USAID's CDCS 2015–2019. We submitted the first draft work plan to USAID on August 31, 2018.

After formal introductions to the USAID Mission in July 2018 and to the Minister of Health in August 2018, we coordinated with them to incorporate USAID's feedback on our draft work plan. In conjunction with the MOH, we devised a strategy to ensure that the GDRC takes ownership of USAID IHP activities from the earliest stages. Together with USAID and the MOH, we designed a staged approach for revising the work plan. After a week of intense programmatic guidance by Ministry experts, we held a workshop to which MOH invited the *Chefs de Divisions Provinciales de la Santé* (DPSs) from our target provinces. We submitted the revised work plan to USAID on October 19, 2018.

Although the technical resources of USAID IHP focused primarily on preparing a strong Year 1 work plan, we supported that process with analysis and planning in cross-cutting areas, including:

- **Gender.** In September, we began work on a gender analysis and implementation strategy, conducting a desk review, a participatory survey of programmatic experts, and a field-based survey on gender norms and behaviors. We then recommended ways to ensure that gender concerns are properly addressed in each USAID IHP activity.
- **Conflict sensitivity.** We conducted a conflict sensitivity analysis in August 2018 and developed a risk mitigation strategy. We completed a desk review, qualitative data collection in our target regions, key informant interviews, and focus group discussions with community members.
- **Capacity development.** We began to refine our capacity development approach in September 2018. Our Program team engaged in intense collaboration—inspired by discussions with USAID experts, MOH counterparts, and DPS partners—to create an approach for building capacity at the organizational, individual, and system levels.

Although it is of course much too early to see results under our intermediate results areas, USAID IHP's intensive planning should be seen as the outcome of activities that covered a substantial set of contract requirements. These activities—research and desk reviews; negotiations; strategy design; concept and proposal writing; planning and coordination with GDRC, international, and technical partners; technical working group meetings; and orientation and training sessions—supported our technical mobilization and work planning processes.

Finally, we engaged in intense efforts to support the USAID IHP monitoring and evaluation (M&E) system. We submitted our Activity Monitoring and Evaluation Plan on September 6, 2018; created and tested our web-based M&E platform; and mapped indicators against data in the DRC's Health Management Information System (HMIS). As the indicator framework became clearer, we also began preparing for baseline household surveys.

As FY2019 opens, our priorities will include opening all provincial offices and completing hiring so that we can ramp up activities at the provincial and ZS levels; conducting analyses and establishing baseline data for each program objective; identifying key beneficiaries and building strong relationships with them at the national, DPS, and ZS levels; and beginning implementation. We will continue to work in conjunction with the GDRC and the MOH, ensuring that our interventions are shaped by their priorities and that we systematically reinforce their capacities to strengthen the country's health system.

I. INTRODUCTION

This report covers the first fiscal year of implementation for USAID’s Integrated Health Program (USAID IHP), known in French as the *Programme de Santé Intégré de l’USAID en République Démocratique du Congo* (PROSANI USAID). The goal of the Program is to work with the Government of the Democratic Republic of the Congo (GDRC) and other stakeholders to strengthen the capacity of Congolese institutions and communities to deliver sustainable quality, integrated health services that improve the health status of Congolese men and women. To meet this goal, USAID IHP has three objectives:

- 1) Strengthen health systems, governance, and leadership at provincial, health zone, and facility levels in target health zones
- 2) Increase access to quality integrated health services in target health zones
- 3) Increase adoption of healthy behaviors, including use of health services, in target health zones

USAID IHP seeks to leverage the potential of decentralization and accelerate reductions in maternal, newborn, and child deaths. The program supports the Ministry of Health (MOH) to tackle challenges identified in the *Plan National de Développement Sanitaire* (PNDS 2016–2020 and the reframed PNDS 2019–2022): poor quality of service delivery and insufficient infrastructure, equipment, human resources, commodity supplies, health financing, health information use, and governance.

Over seven years, USAID IHP will increase the delivery of high-quality, integrated primary health care to 30 million people. We are designing our interventions within the country’s existing health systems framework to ensure that we contribute to their meaningful operationalization, especially by including communities and their respective health committees, known as *Comités de Développement de l’Aire de Santé* (CODESAs), as prime stakeholders of a stronger health system.

I.1. GEOGRAPHIC SCOPE

USAID IHP works in three regions—Eastern Congo, Kasai, and Katanga—and nine provinces. These are Sud-Kivu and Tanganyika in the Eastern Congo region; Kasai-Central, Kasai-Oriental, Lomami, and Sankuru in the Kasai region; and Haut-Katanga, Haut-Lomami, and Lualaba in the Katanga region. Certain activities will take into account the importance of economic corridors. Table I shows USAID IHP’s target regions and provinces, with the number of *Zones de Santé* (ZS) in each.

USAID IHP’s assistance is tailored to meet the needs of each ZS. Program activities in ZS include improving reproductive health and family planning; maternal, neonatal, and child health (MNCH); and malaria. Where these services are already being delivered, we can assist the MOH to deliver additional services for tuberculosis (TB); water, sanitation, and hygiene (WASH); and nutrition.

I.2. PARTNERSHIPS

Abt Associates, as the prime contractor, leads a team of core subcontract partners, including two intimately involved in the predecessor project (the Integrated Health Project Plus, or IHPplus): the

Table I: USAID IHP Regions, Provinces, and Zones de Santé		
Region	Province	Zones de Santé
Eastern Congo	Sud Kivu	34
	Tanganyika	11
Kasai	Kasai-Central	26
	Kasai-Oriental	19
	Lomami	16
	Sankuru	16
Katanga	Haut-Katanga	26
	Haut-Lomami	16
	Lualaba	14
TOTAL		178

International Rescue Committee (IRC) and Pathfinder International. Supporting partners include six niche partners that combine international expertise in health programming with innovative solutions for fragile states: Bluesquare, iPlusSolutions, Matchboxology, Mobile Accord/Geopoll, Training Resources Group (TRG), and Viamo. The Kinshasa School of Public Health will be called upon for certain research activities as a partner, as well. Key government beneficiaries and partners are the MOH at national, *Division Provinciale de Santé* (DPS), ZS, and health facility levels; community members; health committees, known as *Comités de Développement de l'Aire de Santé* (CODESAs); community health workers (*Relais Communautaires*, or RECOs); and health care providers.

USAID IHP's efforts require collaboration with various stakeholders, including the MOH, Breakthrough Action, Challenge TB, and IHAP, , and other agencies and donors supporting health systems strengthening. The Program is also coordinating closely with numerous USAID programs to ensure complementarity and to leverage resources toward common goals. These include the Global Health Supply Chain-Technical Assistance (GHSC-TA) Project, the MEASURE Evaluation Phase IV project; the Integrated Governance Activity (IGA); Food for Peace; and the Strengthening Value Chains Activity.

2. START-UP

The first year began on January 29, 2018, but start-up was interrupted when USAID communicated a stop-work order to Abt on February 15 as a result of a protest of the contract award. The stop-work order was lifted on May 26, 2018, and we recommenced start-up activities on May 29, 2018. This delay getting started with activities compressed the work period for this fiscal year. This report therefore covers approximately four months of operations, June–September 2018.

2.1. OPERATIONAL START-UP

CONTEXT

We initiated start-up activities on February 1, 2018, immediately after contract award. This included beginning to draft a mobilization plan, moving to hire staff named in the proposal, commencing internal processes to open local bank accounts, updating country-level registration, and obtaining visas for the start-up team to mobilize to the DRC. When mobilization resumed after the stop-work order was lifted, we submitted third-country national waivers for the Chief of Party (COP) and Director of Finance and Administration on June 9, 2018; they were approved by USAID on July 12, 2018. This, along with delays in obtaining DRC visas, delayed arrival of the start-up team in Kinshasa until the week of July 16, 2018. Upon arrival, the mobilization team and our staff, led by COP Dr. Peter Eerens, met with USAID/DRC and began preparing to hold the initial team building and work plan meeting with subcontract partners beginning July 23, 2018.

ACTIVITIES IMPLEMENTED THIS YEAR

Approved subcontractors

All subcontractors participated in the July 23–27, 2018, work planning workshop (see section 2.2), authorized either through fully executed subcontracts or by Letter Contracts pending the definitization of final agreements. Following this workshop, we realigned scopes of work and budgets to support updated work plan activities. Upon arrival in Kinshasa, COP Dr. Eerens met with the Kinshasa School of Public Health to discuss its anticipated participation as a research partner later in the program period.

Table 2: USAID IHP Subcontracting Status at end of FY2018

Subcontractor	Subcontract Status
International Rescue Committee	Letter of Authorization pending fully definitized subcontract
Pathfinder International	Letter of Authorization pending fully definitized subcontract
Bluesquare	Subcontract executed
Mobile Accord, Inc.	Initial agreement executed for work planning; final subcontract agreement to proceed once USAID has approved work plan
iPlusSolutions	Subcontract executed
Matchboxology	Initial agreement executed for work planning; final subcontract agreement to proceed once USAID has approved the work plan
Training Resources Group	Subcontract executed
Viamo PBC	Subcontract executed

Recruited and mobilized Program staff

Following the resumption of program activities after the stop-work order was lifted, **COP Dr. Eerens** and **Deputy COP** Pascal Ngoy began work in July, as did a number of other senior staff. These included the **Director of Finance and Administration**, Serge Reckoundji; the **Health Systems Strengthening Advisor**, Basile Yangala (Objective 1 Lead); and the **Infectious Disease Advisor**, Jean-Caurent Mantshumba. In August, additional senior team members joined the staff, including the **Director of Research, Monitoring, and Evaluation**, Leon Kadiobo and the **Knowledge Management and Communications Director**, Landry S. Malaba. **Director of Service Delivery** Narcisse Embeke (Objective 2 Lead) began work in early September. As of the end of the fiscal year, approvals were in process but not yet completed for the **Social and Behavior Change Advisor**, Jean-Baptiste Mputu (Objective 3 Lead). We hired **Regional Directors** Janvier Barhobagayana, Armand Utshudi, and Ndalumbo Kanku in July. They were mobilized to their regional posts during the week of August 13, 2018, after two weeks of work planning in Kinshasa.

Hiring of additional Program staff continued at an active pace throughout July and August, but slowed in September due to the extensive amount of time senior staff needed to focus on work planning in August. This greatly limited time available for senior staff to conduct interviews and make hiring decisions. The pace of interviewing and hiring picked up again in September, the results of which will be reflected in reporting for Quarter 1 of FY2019.

Additional delays in deploying personnel resulted from the need for some selected employees to provide current employers with 30 days' notice prior to starting work on USAID IHP, as well as by the time required to conduct comprehensive reference and background checks. During the first few months of Program operations, there were significant changes to the organizational chart, as once on the ground we found some needs not entirely covered and we changed some structures to be more responsive to the needs of site offices. These revisions are reflected in a proposed budget realignment submitted to USAID on October 22, 2018. Following discussions with USAID, we also decided to cut back on the number of personnel in the *Equipes d'Encadrement Intégrées* to a smaller start-up number (25 teams of three instead of 50 teams).

We agreed that we will evaluate, after one to two years, whether this model will work and how well these teams are able to develop the kind of relationship with the ZSs and health facilities needed to carry out the work using a collaboration, learning, and adapting (CLA) approach. As of September 30, 2018, 24 project staff were in place in Kinshasa, Bukavu, Kananga, and Lubumbashi.¹

Identified and procured office space

Kinshasa. We decided to establish our offices in Gombe in Kinshasa for security and accessibility reasons. We identified seven potentially suitable locations and ultimately selected the building that previously housed IHPplus and other USAID programs. As of the end of FY2018, we were preparing to move from our temporary quarters in the offices of the former Health Finance and Governance project into the permanent location; the lease for the permanent program office was fully executed on October 9, 2018. The landlord allowed us to move in on two partially finished floors before the official move-in date of November 1, 2018.

Regions and provinces. We faced a number of challenges in finding buildings to house regional and provincial Program offices, with inadequate infrastructure and the high cost of real estate posing

¹ As of October 30, the date this report was submitted, USAID IHP has 36 staff in place in all offices.

particular difficulties. The shortage of available real estate makes it difficult to negotiate rent with landlords, who want to escalate prices over time. In some locations mining companies and other private sector entities have considerably driven up prices on scarce property. Teams composed of our Regional Directors and Interim Security Manager visited a number of office buildings proposed by real estate intermediaries. They found that available space that meets our criteria is rare, with extensive renovation being required prior to occupancy. USAID IHP believes that moving to a co-location model, where we share space with other USAID-funded programs, would be the best solution wherever possible. This would not only resolve office space problems but would also create better synergy across critical partnerships. As of the end of the fiscal year, we have located several office spaces and are in negotiations, with an office lease agreement for the Kananga office signed on October 1, 2018, just as fiscal year 2019 began.²

In each region we will co-locate a regional and provincial office, with other provinces in that region establishing their own office. Program offices will be distributed as follows:

Eastern Region

- Eastern regional office and South Kivu provincial office—co-located in Bukavu
- Uvira branch office, reporting to South Kivu provincial office
- Tanganyika provincial office—Kalemie

Kasai Region

- Kasai regional office and Kasai-Central provincial office—co-located in Kananga City
- Kasai-Oriental provincial office—Mbujimayi
- Lomami provincial office—Kabinda
- Sankuru provincial office—Lodja

Katanga Region

- Katanga regional office and Haut-Katanga provincial office—Lubumbashi
- Haut-Lomami provincial office—Kamina
- Lualaba provincial office—Kolwezi

Procured supplies and equipment

Based on the approved procurement plan, USAID IHP procured, prepared, and shipped IT equipment (computers, servers, monitors, docking stations, etc.) from the U.S. to the DRC. The Program team completed, imaged, and configured approximately 160 computers and associated software and servers. Others are in process. There was some delay, as the Program had to wait for tax exemption documentation from the GDRC (via USAID), which was obtained on September 28, 2018. At this point the equipment was immediately shipped to the DRC.³

From June 15 through August 25, 2018, we completed the inventory and receipt of furniture, equipment, and vehicles dispositioned to us from the IHPplus project. We held discussions with the Pathfinder/Management Sciences for Health team and USAID about turnover of equipment in the provinces and in Kinshasa. We also put in place storage and security plans for the inventory until the

² Several others have been signed since the end of FY2018.

³ As of the end of October, all computers have arrived in Kinshasa. Customs formalities are underway for deliveries.

USAID IHP offices could be fully established. During the last quarter of FY2018 we submitted a revised procurement plan to USAID based on the Program's current needs; it is currently pending approval prior to implementation.

2.2. TECHNICAL START-UP

CONTEXT

Numerous meetings with subcontractors and other implementing partners have revealed rich available resources for USAID IHP to carry out its mandate. Both large and niche subcontractors in the Abt consortium command a range of technological applications to enhance our work within the MOH and community organizations. Most of these partners are already working in the DRC, giving us a platform of ready-made knowledge and the ability to get the Program up to speed quickly. Each partner was included in the work planning activities in July. They have provided their inputs into the work plan submitted on August 30, 2018, and the revision submitted on October 19, 2018.

ACTIVITIES IMPLEMENTED THIS YEAR

Held post-award kick-off meeting

On June 5, 2018, USAID held a post-award kick-off meeting, led by the then-Contracting Officer, to introduce the team and describe USAID's expectations and vision for USAID IHP. The USAID Mission Director noted that this is the largest program that USAID/DRC has ever had in its portfolio and that USAID considers it the Mission's flagship program. He described USAID's high expectations for the work to be accomplished to strengthen the MOH at the DPS and ZS levels, improve service delivery, and improve the country's health statistics. As a rare seven-year Program (with a four-year base period and three-year option period), USAID IHP has time to achieve measurable impacts in the target provinces.

The kick-off meeting included introductions of all present, especially the Contracting Officer's Representative (COR), and brief presentations by all relevant USAID experts, including those for gender, environment, MNCH, and reproductive health and family planning. The Contracting Officer concluded with a brief review of the contract and a question-and-answer session. The USAID IHP team asked a few questions and described our plan for mobilization and start-up.

Formally introduced the Program to USAID and the Ministry of Health

Once the USAID IHP senior management team was complete in mid-July, official introduction of the Program and our leadership could take place. We held formal meetings with USAID Mission leadership during the July 23–27, 2018, work planning, team building, and orientation meeting. Meetings with the MOH happened at a later stage.

The meeting with his Excellency the Minister of Health occurred on August 12, 2018. The welcoming atmosphere of this meeting allowed an inspiring conversation about the importance of the new Program in the context of the MOH's decentralization. The agreement to work toward strong collaboration and to give the Program launch a special character shaped the work that took place in the weeks that followed. This discussion included suggesting to the still-operational IHPplus team and the MOH that we hold a closure meeting on lessons learned from the previous project, to describe activities and achievements as a precursor to introducing the new USAID IHP in a future launch event. The "lessons learned" event was held in August with the help of USAID IHP.

This first official meeting at the MOH was followed by an equally productive meeting at the Office of the *Secrétaire Général* of the MOH on August 21, 2018. COP Dr. Eerens provided a more in-depth picture of

USAID IHP, sharing insights about how the Program could be anchored within the framework of the MOH. We requested assistance with official introductions for the Program in the provinces. An earlier exchange of ideas between the MOH and USAID about using the *Direction Générale de l'Organisation et de Gestion des Services et des Soins de Santé* (DGOGSS) as USAID IHP's anchor point within the ministry and its different departments was formally accepted.

Developed Year 1 work plan

USAID IHP held a five-day work planning workshop in Kinshasa from July 23–27, 2018. In agreement with the USAID Mission and due to the timing of start-up, representatives from the MOH did not participate in the work planning event. Thus, the workshop became a planning, orientation, and team-building event for Program partners only, with occasional participation by USAID officials. At this workshop, staff from the Abt home office, the offices of our subcontractors, and Program staff hired as of that point studied the contract, the different program documents, and MOH health sector documentation (including policies, plans, strategies, guidelines, and evaluations) and presented their various roles in the Program.

On day three, the Program's USAID COR introduced five USAID-funded programs with which USAID IHP needs to coordinate: IGA, the MEASURE Evaluation IV project, Food for Peace, the GHSC-TA project, and the Strengthening Value Chains Activity. Representatives from the Kinshasa School of Public Health also participated in the workshop as a future USAID IHP implementation partner.

During the weeks after the workshop, USAID IHP continued to prepare for collaboration with the MOH. Team members incorporated outcomes from workshop discussions into the draft work plan and continued conversations with other partners. We submitted a draft work plan to USAID on August 31, 2018, and received official feedback on September 18, 2018. Discussions with USAID on proceeding to a more robust work plan after we were able to meet with the MOH led to a series of meetings in the following weeks, with the work plan revision submitted on October 19, 2018.

Led IHPplus-to-USAID IHP transition workshop

Following the July work planning workshop and as part of the USAID IHP mobilization plan, we organized the handover of activities from IHPplus, the predecessor project. During the first meeting with that project's leadership, we jointly agreed to invite the MOH to lead a formal Lessons Learned and Actions to be Taken Workshop on August 23, 2018, to ensure that we build on IHPplus's experiences. Because the official USAID IHP visit to the office of the *Secrétaire Général* of the MOH took place only two days before it began, the lessons learned workshop provided an additional opportunity to hold in-depth planning discussions with MOH counterparts. The workshop informed adjustments and clarifications to the draft work plan and marked the formal start of the MOH-USAID IHP collaboration.



Dr. Body Robert Ilonga, Directeur Général, MOH, at an IHPplus-to-USAID IHP transition workshop

Conducted joint planning with the MOH to revise the work plan

Guided by USAID's feedback on our draft Year 1 work plan and inspired by the positive welcome from the MOH, USAID IHP management worked with the MOH to design a strategy to ensure GDRC ownership of the Program from the earliest stages. In collaboration with USAID, we then developed a staged approach for revising the work plan.

Stage one. This included small team meetings between USAID IHP and USAID staff for each Program objective and for cross-cutting areas. We jointly prepared a detailed presentation of the Program for the MOH. This included a detailed orientation for the DGOGSS, during which we presented the Program and its three objectives, with examples of activities and the approaches we will take to achieve results.

Stage two. A first meeting provided a Program orientation to MOH leadership within the ministry's premises. It was attended by all directors of the Ministry and by USAID mission representatives. We presented an overview of USAID IHP, particularly its mission to target institutions and communities, and outlined the proposals thus far elaborated by Program staff. We requested that MOH experts debate and evaluate these proposals.

This successful introduction was followed by a week-long intensive one-on-one collaboration with various division heads, bureau heads, and special program heads within the Ministry. We worked with our MOH counterparts to test our proposals for particular activities to ensure they align with MOH strategies and that USAID IHP's mission and original proposed activities are relevant to national GDRC programs. We also worked with the MOH to prepare for detailed discussions with provincial officials.

Stage three. At this point, we invited DPS representatives from the nine provinces to provide their insights about feasible, high-impact interventions that are consistent with the reframed PNDS 2019–2022. We held a five-day work session during which we introduced USAID IHP to the provinces, reviewed proposed activities, and provided region- and province-level context. We also shared budget estimates in preparation for a budget update and realignment to be submitted to USAID on October 23, 2018. With commitment from the MOH, the work planning teams succeeded in condensing their original large list of activities and their corresponding budgets. The work session gave our province-level colleagues early insights into the Program's limitation while also helping them understand how reductions were achieved. The entire exercise led to a revised work plan that also had implications for the Program Management Plan (PMP). Final work on the Activity Management and Evaluation Plan (AMEP) was also underway. During a final week of consultative meetings, USAID IHP staff met internally to discuss the Program, review draft activities, and incorporate comments and changes.

Built relationships with regional and provincial government bodies

Eastern Congo. From July through September, USAID IHP's Eastern Congo Regional Director met with various MOH partners in South Kivu, including the Provincial Minister of Health, the *Chef de DPS*, the *Médecin Inspecteur Provincial*, and the *Centrale de Distribution Régionale de médicaments*, to share information about USAID IHP, our objectives, and our planned activities. The Regional Director participated in meetings of the working group of the *Comité Provincial de Pilotage du Secteur de Santé*. Discussions centered on problems with the availability of tools for collecting data to identify and understand epidemics, the need for provincial coaches and trainers in ZSs, and policies for redistributing medicines for ZS beneficiaries.

In addition, the Regional Director travelled to Tanganyika from September 17 to 26, 2018, to better understand the major challenges facing USAID IHP in that province. These include persistent epidemics, malnutrition, a high prevalence of malaria, lack of access to health care, major problems with the supply

chain for medicine, and stock-outs of certain items in the *Centrale de Distribution Régionale de médicaments*, as well as poor-quality roads and long distances to travel between the 11 target ZSs.

In Sud-Kivu, the Regional Director participated in survey meetings to analyze data on diseases with potential to cause epidemics, particularly cholera, measles, and malaria. We provided technical support to help the DPS to put in place a contingency plan for an Ebola outbreak, since there are currently cases of the disease in Nord Kivu.

Kasaï. Our Kasaï Regional Director met with the Manager of the *Centrale d'Administration et de Distribution des Médicaments Essentiels du Kasaï* (CADIMEK) to launch coordination of USAID IHP activities with the depot's operations. Thanks to funding from other donors, the CADIMEK has relocated to a new facility in a Catholic Church compound where it can store and distribute pharmaceuticals and medical supplies to most Kasaï region health facilities (hospitals and health centers). The CADIMEK manager requested support to ensure that all facilities have a functioning logistics systems that will enable them to regularly order medicines and medical and laboratory supplies and avoid stock-outs. Preliminary discussions centered on using coaching as a capacity building methodology, rather than simple logistics training (which has been done in previous years without strong results).

Katanga. In August, our Katanga Regional Director and our Haut-Katanga Provincial Director participated in meetings with the Haut-Katanga DPS to discuss the *Contrat Unique*, the tool established by the MOH to harmonize the means and visions of different DPSs. On September 24, 2018, they met with the *Chef de Division* of the Haut-Katanga DPS and the *Chef du Bureau d'Appui Technique* to learn more about the operations of the DPS and the *Inspection Provinciale de la Santé* (IPS). They discussed the coordination of planning, budgeting, and support between USAID IHP and the Haut-Katanga DPS and IPS. On September 26, 2018, the USAID IHP team in Katanga met with the IPS to understand its needs, learning that IPS operations are hindered by the lack of a *Plan d'Action Opérationnel* (PAO) and a scarcity of workers. Further challenges include *Médecins Inspecteur Provincial* who have not yet been trained as legal officers, a lack of regulations, and a lack of understanding about the regulations that do exist.

The Regional Director and Haut-Katanga Provincial Director participated in September 26–28, 2018, working group meetings with all DPS bureau heads (human resources, training, technical assistance, HMIS, specialized services) to review their institutional capacity building needs and the need for services in areas such as blood transfusions, MNCH, malaria, HIV, vaccinations, tuberculosis, and leprosy.

Initiated regional-level coordination with other programs and implementing partners

The Eastern Congo Regional Director met with Food for Peace to talk about ways to ensure synergy between that program and USAID IHP (see section 6.3). He also participated in a working group meeting in South Kivu for all USAID and other donors active in the province. Participants discussed regular quarterly meetings, mobilization of resources, and the development of work plans for ZSs.

In September, our Kasaï Regional Director met with international NGOs and with the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Health Organization, and the UK Department for International Development (DFID)-funded *Accès Aux Soins de Santé Primaires* (ASSP) project, which are active in the health sector in Kasaï-Central province. He introduced USAID IHP and gathered up-to-date information on challenges and gaps that need to be addressed to support integrated delivery of services in the province and in the region.

The Kasaï Regional Director also met with IGA to understand its activities and to plan for coordination between the two programs in the Kasaï region. An IGA study of the institutional capacity of the IPSs in Kasaï-Central, Kasaï-Oriental, Katanga, and Sud-Kivu revealed weaknesses in IPS health governance, which impacts the institutions' ability to collaborate with DPSs. The lessons from the IGA study will help

us avoid duplication and encourage coordination, especially as we plan and implement the Participatory Institutional Capacity Assessment and Learning (PICAL) tool in support of Objective 1.

3. OBJECTIVE I

STRENGTHEN HEALTH SYSTEMS, GOVERNANCE, AND LEADERSHIP AT PROVINCIAL, HEALTH ZONE, AND FACILITY LEVELS IN TARGET HEALTH ZONES

3.1. CONTEXT

Opportunities. The DRC's decentralization process offers a favorable institutional framework that encourages health institutions to properly fulfill their mandates. With proper support and training, this process could help the country boost development in general and in particular contribute to improvements in the quality, equity, and efficiency of health services offered to the Congolese population.

The existence of regulations and various task forces within the MOH are major advantages. The MOH has adopted health system strengthening as a principal strategy of health policy in the country. This strategy is updated every five years in the PNDS, which translates the MOH's vision into action. USAID IHP will support the MOH in putting the PNDS into practice, tailoring support to the needs of DPSs and our target ZSs. The reframed PNDS 2019–2022 recognizes the need for a paradigm shift: from a focus on means to a focus on results, accompanied by selected doable, high-impact priority actions consistent with available resources. USAID IHP's institutional capacity building strategy adapts to this new paradigm, as do our planning, implementation, and M&E strategies.

In 2018, the MOH proceeded with an in-depth mid-term review of the implementation of the PNDS 2016–2020. This review led to recommendations that the implementation focus be narrowed into feasible, high-impact interventions affordable within existing resource envelopes. In addition, the adjusted plan also revises the time frame to 2019–2022, making it easy for USAID IHP to align more fully with the MOH's priority-setting and implementation calendar.

Constraints. The biggest constraint to institutional capacity building in the context of decentralization is that the transfer of responsibilities must be accompanied by a transfer of resources, which is not yet happening. Provinces and the *Entités Territoriales Décentralisées* can barely finance their local health services; they are turning almost exclusively to national-level sources and international development partners. In addition, most MOH activities are not following the PNDS program, due to insufficient implementation mechanisms and the absence of a clear financing plan. Even though regulations exist, they are not well-known, disseminated, understood, or enforced—putting them into practice at all levels will require considerable effort.

3.2. ACTIVITIES IMPLEMENTED DURING THE YEAR

To improve the functioning of target health institutions so they can properly fulfill their mandates, USAID IHP will support the DPSs and ZSs to work together with the *Entités Territoriales Décentralisées* to identify other sources of revenue, so they can use their own resources to finance local health services.

The Health Systems Strengthening Advisor and his team worked with USAID and MOH staff during FY2018 to develop plans for key Year I activities under Objective I. We will support the MOH with operational planning and especially with implementation of the PAOs in the DPSs and target ZSs. We will help pilot innovative financing approaches that can contribute to pooling mechanisms for resources and the purchase of services to reduce out-of-pocket payments for health care. USAID IHP will use numerous tools for monitoring, analysis, and processing of health information at all levels, as described in Chapter 8 of the Activity Monitoring and Evaluation Plan (AMEP). The program will also support the MOH to help familiarize stakeholders at decentralized levels with the regulations.

Evaluated national programs, frameworks, and concepts as they relate to USAID IHP's scope of work

During FY2018, the Program focused on developing a common understanding of Objective I among our staff, MOH teams, and USAID technical experts. We held a number of meetings that led to the creation of a strategy and selection of key Year I work plan activities linked to Objective I. Under USAID IHP, this objective is different from similar efforts under previous USAID integrated health programs in the DRC—it will strengthen institutional governance and leadership to enable Congolese to drive their own development with their own resources. Our meetings with the MOH introduced a different working relationship between the Program and our Ministry counterparts and reinforced our vision to strengthen the MOH to implement its mandate through its newly decentralized DPS and ZS structures.

IRI.1: ENHANCED CAPACITY TO PLAN, IMPLEMENT, AND MONITOR SERVICES AT THE PROVINCIAL, HEALTH ZONE, AND FACILITY LEVELS

Under this intermediate result USAID IHP will adopt proven methodologies that empower DRC counterparts to improve and scale up systems and services.

Oriented USAID IHP staff on the PICAL tool for institutional capacity building

As part of the initial preparations to implement the PICAL assessment tool in all USAID IHP provinces and adapt and expand it to the ZS level, we held an internal briefing on September 11, 2018, to familiarize our Kinshasa-based staff with the tool. The purpose of this briefing, which was led by TRG, was to ensure that before we begin carrying out baseline PICAL assessments during the first quarter of FY2019, our staff understand how the tool works and how we will use it to develop tailored capacity building plans.

Started work to facilitate the use of performance dashboards

Initial work took place to create a data system from which provinces can pull information to populate different performance dashboards. Performance dashboards are based on having sufficient data regarding each health facility in order to catalog where it began (as of the beginning of USAID IHP) for many factors. These might include number and level of staff, type of facility, with/without electricity or running water, GPS coordinates, numbers of patients seen per week, and many other factors that can go into reporting on a performance dashboard that pulls data from a well-documented database. Documenting or updating the documentation on health facilities such as the one pictured will enable us to identify candidate facilities for rehabilitation and to track changes over time. This work links with our creation of an M&E system, since it addresses the same challenges of rendering existing data systems accessible for easy visualization of data.



Photo: Bluesquare

USAID-IHP initiated work to populate dashboards with information about health facilities. Facilities like this one in Sandoa HZ in Lualaba can now easily be identified as possible candidates for rehabilitation.

IRI.2: IMPROVED TRANSPARENCY AND OVERSIGHT IN HEALTH SERVICE FINANCING AND ADMINISTRATION AT PROVINCIAL, HEALTH ZONE, FACILITY, AND COMMUNITY LEVELS

Under this intermediate result, USAID IHP will strengthen provincial and ZS oversight mechanisms.

Prepared alignment with MOH guidelines on the role of the *Inspections Provinciales de la Santé*

After we first presented USAID IHP to the MOH, we held a separate meeting with the Inspectorate General to introduce the Program and exchange ideas about how to support this ministry function. This included how we can support the province-based, decentralized IPSs. The Inspectorate General and IPSs are in charge of verifying compliance with existing guidelines for a range of issues, such as compliance with MOH central-level procurement and management requirements, and for human resources guidance, including the MOH's gender-based recommendations. Collaboration in this area is important for all subsequent Program work on MOH oversight of activities at the operational level, including oversight of accountability, transparency, and fraud detection,

Initiated collaboration with the USAID-funded Integrated Governance Activity

During the work planning meeting, the IGA team was formally introduced to USAID IHP staff. We immediately agreed on a convergence of interests, with IGA addressing health through fundamental work on governance with local government structures, and with USAID IHP working within health sector programs while promoting governance. This agreement is consistent with USAID's expectations for synergy among existing programs to achieve the mission's CDCS goals. The work plan included provisions for close collaboration between USAID IHP and IGA. IGA also highlighted its impact evaluation taking place in multiple sites, which will require us to limit or entirely desist from activities in those areas even though they are in our target areas. This will require further discussions with both USAID and IGA.

IRI.3: STRENGTHENED CAPACITY OF COMMUNITY-SERVICE ORGANIZATIONS (CSOs) AND COMMUNITY STRUCTURES TO PROVIDE HEALTH SYSTEM OVERSIGHT

Designed support to help *Cellules d'Animation Communautaire*, CSOs, and CODESAs hold the health system accountable

During FY2018, the Program used several opportunities to explore how far the MOH intends to go in giving more weight to dynamics that strengthen community-based accountability. The MOH's new community strategy was presented during the IHPplus-to-USAID IHP lessons learned transition workshop. During the question-and-answer session, the Ministry stressed that the *Cellules d'Animation Communautaire* are much more important to this process than the CODESAs. In this way, the MOH seeks to avoid medicalizing community structures as has happened in the past.

Similarly, during and after the USAID IHP orientation meeting at the MOH, we held conversations with the *Chefs de DPS* to ensure that our interpretation of the strategy was sound. Our understanding was that we should support provincial leaders to challenge ZS leaders to urge nurses in health facilities to re-engage with communities—not to mobilize them for their own interests but instead to listen to concerns, identify community leaders, and empower communities to create participatory initiatives.

IRI.4: IMPROVED EFFECTIVENESS OF STAKEHOLDER COORDINATION AT THE PROVINCIAL AND HEALTH ZONE LEVELS

Developed strategies to strengthen DPS coordination capacity

The Program did not carry out any specific activities under this intermediate result in FY2018. During work plan preparation, however, we discussed strategies for reducing the coordination challenges faced by the MOH. We adopted several strategies: 1) be an exemplary partner and ensure that USAID IHP interventions, approaches, and systems are aligned, to greatly reduce the MOH's transaction costs; 2) develop collaborative and well-coordinated partnerships with other USAID-funded programs at the ZS, DPS, and national levels; and 3) be proactive in contacting other partners. We encouraged our Regional

Directors to reach out to partners to demonstrate our willingness to collaborate in support of MOH goals and objectives.

One important step in this strategy is to be fully familiar with the tools used by the MOH. We made sure staff understand the need to study those tools, excel in their use, and become experts. This includes policy documents, program documents, planning tools, and supervision tools.

IRI.5: IMPROVED DISEASE SURVEILLANCE AND STRATEGIC INFORMATION GATHERING AND USE

Prepared for support to strengthen HMIS infrastructure

As we prepared for activities to strengthen HMIS infrastructure, our Program experts held preliminary discussions and exchanged ideas with the MOH's HMIS specialists. We also detailed areas where USAID IHP support can have the greatest impact. These could include providing specifications for digital collection and storage of data for the PICAL tool, providing health systems data feedback to CODESAs, creating templates for presenting data at the provincial level, increasing the use of mobile phones for epidemiological surveillance, or optimizing tools to improve the analysis and presentation of existing data.

During the coming quarters, we will carry out in-depth studies of existing data systems and data sources and prepare the architecture in which data storage, transfer, sharing, and exploration can take place. We will also load data onto new data architecture, test it or run simulations for future use, create templates to test the applicability of several design concepts, and demonstrate its use.

IRI.6: IMPROVED MANAGEMENT AND MOTIVATION OF HUMAN RESOURCES FOR HEALTH

Although USAID IHP did not undertake any major activities under this intermediate result, the theme of human resources for health was prominent during all discussions. We incorporated important human resources management issues (training, mentoring, continuing education, and motivation) into our planning. We also agreed to help provinces explore essential issues such as recruitment, remuneration, promotion, and retirement as we move into implementation.

IRI.7: INCREASED AVAILABILITY OF ESSENTIAL COMMODITIES AT PROVINCIAL, HEALTH ZONE, FACILITY, AND COMMUNITY LEVELS

Successful USAID support to the DRC's essential generic medicines program will require strict and well-functioning coordination between GHSC-TA and USAID IHP. GHSC-TA distributes essential medicines down to the ZS level, but from there onwards it is USAID IHP's responsibility to support distribution, stock-taking, and quantification. During this fiscal year, the Program engaged in planning under this intermediate result, to be ready to commence interventions as soon as the work plan is approved. We consulted with GHSC-TA at the national level, but also established contact with that project's province-level technical advisors when possible. USAID informed GHSC-TA and USAID IHP that it will adjust its essential medicines support strategy to be more compatible with MOH modes of supply and distribution. Initial discussions on this took place and will continue during next quarter.

IR I.8: STRENGTHENED COLLABORATION BETWEEN CENTRAL AND DECENTRALIZED LEVELS THROUGH SHARING OF BEST PRACTICES AND CONTRIBUTIONS TO POLICY DIALOGUE

Participated in working meetings of the governance and financing commissions of the of the National Steering Committee of the MOH

USAID IHP participated in technical Commission meetings whose contacts are indispensable to our ability to understand MOH dynamics. Going forward, these meetings will provide an ideal framework for sharing on-the-ground lessons learned that arise through the Program and for influencing the development of positive policies and regulations that will sustainably improve the health system in the DRC. We will remain actively engaged to ensure that these meetings are as productive as possible.

4. OBJECTIVE 2

INCREASE ACCESS TO QUALITY, INTEGRATED HEALTH SERVICES IN TARGET HEALTH ZONES

4.1. CONTEXT

Factors limiting demand and access to quality health services in the DRC are multiple. They include inadequate infrastructure, shortages of essential generic medicines and medical supplies and equipment, as well as negative attitudes (such as sexism) by health care providers, long distances to reach health centers, and inappropriate medical referrals. Additional health system barriers include poor geographic health coverage and low-quality health services offered by unmotivated and poorly supervised staff. In this environment, USAID IHP's mandate is to deploy *Equipes d'Encadrement Intégrées* to work with *Equipes Cadre de la Zone de Santé* (ECZSSs) and facilities to help them provide evidence-based, integrated packages of care for antenatal care, basic emergency obstetric and newborn care, comprehensive emergency obstetric and newborn care, postnatal care, access to the *Programme Élargi de Vaccination*, integrated management of childhood illnesses, and integrated community case management. In addition community based services such as infant and young child feeding, tuberculosis services and WASH will also be supported at community level.

Opportunities. MOH revisions to the PNDS offer favorable opportunities for USAID IHP to support real institutional reforms that can strengthen service delivery across the health system. Helpful central-level MOH reforms include the establishment of a *Division Prestation et Assurance Qualité des Soins* in the *Division des Soins de Santé Primaires* and the publication of the first Health Services Delivery Evaluation report in the DRC. This report, to which USAID contributed support, which was carried out by the Kinshasa School of Public Health in July 2018, provides data on each province's need for health services capacity building and training to improve the quality of services offered to the population. The report clearly demonstrates the diversity of needs among provinces.

The revised PNDS also presents opportunities for real and lasting change. The first strategic path of the reframed PNDS aims to improve availability, geographic access, and the quality of health services while also ensuring equity. It focuses on the provision of health services in reproductive health; MNCH; infectious diseases; chronic diseases; and non-transmittable diseases. It also emphasizes ways to better protect the population against health risks such as epidemics, catastrophes, and other emergencies.

As we ramp up support for service delivery, additional opportunities for collaboration to increase impact are offered by the existence of a number of MOH financial and technical partners already working in USAID IHP-supported provinces. These include:

- *Projet de Développement de Système de Santé*, which supports MNCH in Haut-Katanga, Haut-Lomami, and Lualaba.
- The Mashako Plan on Routine Vaccination, which aims to increase vaccination coverage by 15 percentage points by the end of 2019. Three of our target provinces—Haut-Katanga, Haut-Lomami, and Tanganyika—are involved in this plan.
- Evidence to Action for Family Planning interventions at the community level in Kasai-Central, Lomami, and Lualaba.
- Challenge TB, which supports tuberculosis activities in Kasai-Central, Kasai-Oriental, Lomami, Sankuru, and Sud-Kivu.
- *Action Damien* in Haut-Katanga, Haut-Lomami, Lualaba, and Tanganyika.
- Food for Peace nutrition and WASH activities in Kasai-Oriental and Sud-Kivu.

Constraints. As shown in the Health Services Delivery Evaluation report, the provision of health care services remains very challenged in many provinces, especially those formed by the new national

decentralization efforts (Haut-Lomami, Lomami, Lualaba, Sankuru, and Tanganyika). These provinces are most in need of support for health care services delivery. The insufficiency of essential generic medicines constitutes another barrier to access to quality health care services at both the facility and community levels. Information in the District Health Information System² (DHIS2) shows low availability of the 13 commodities that can save mothers' and children's lives, as well as malaria commodities. Since essential generic medicines are the main input into service delivery, USAID IHP will need to coordinate with the GHSC-TA project to follow the supply chain from the ZS level on to the health facility level, particularly to let facilities know when they can expect to receive specific drugs.

4.2. ACTIVITIES IMPLEMENTED DURING THE YEAR

During this first year of USAID IHP operations, our main activities under Objective 2 centered on establishing relationships and making initial contacts with MOH experts in the *Division de Prestation et Assurance Qualité des Soins*, USAID experts and other implementing partners, and programs that address specific health conditions and diseases.

IR 2.1: INCREASED AVAILABILITY OF QUALITY, INTEGRATED FACILITY-BASED HEALTH SERVICES

Coordinated with the government and with DRC health sector programs

On September 13, 2018, USAID IHP participated in the MOH's routine quarterly meeting of the *Commission Prestation, Mise en Œuvre, Suivi, et Evaluation*, which took place at the MOH's *Division des Soins de Santé Primaires*. Several other partners also attended, including the Global fund, *Santé Rurale*, and USAID's Maternal Child Survival Program. A number of agenda topics were relevant to USAID IHP:

- Resolutions from the July 2018 meeting of the *Comité National de Pilotage-Secteur de Santé*
- Validation of normative documents from the *Programme National de Santé Oculaire et Vision*
- Appropriate integrated supervision tools for HIV, tuberculosis, and malaria

Initiated coordination with DRC programs related to specific diseases and health issues

During FY2018 we launched USAID IHP coordination with a number of DRC programs that address specific diseases or health needs. Chapter 6 describes these meetings, but they included contacts with the *Programme National de Lutte Contre le Paludisme* (see section 6.1), the *Prise en Charge Intégrée de la Maladie du Nouveau-né et de l'Enfant* (see section 6.2), the *Programme National de Nutrition* (PRONANUT) (see section 6.3), the *Programme National de Santé de la Reproduction* (see section 6.4), the *Programme National de Lutte Contre la Tuberculose* (see section 6.5), and the *Programme Élargi de Vaccination*.

Committed to incorporating the MOH's integrated quality improvement approach

USAID IHP seized on several opportunities to ensure all Program staff are familiar with the MOH's integrated quality improvement approach (*Demarche de la Qualité Intégrée*), particularly as we prepared for the IHPplus-to-USAID IHP transition workshop. During that workshop, we clearly articulated the Program's support and commitment to the MOH's quality improvement approach. Our staff committed to studying the strategies and guidelines so they can apply them in each program area.

Designed interventions to improve RECOs' clinical skills

During work planning, we made a full inventory of existing courses. There is a wealth of training materials we can use for short competency-based training; we will need to work with ECZSs to determine the best ways to make such material available to the different DPSs and ZSs and to help them set up systems that give local providers access to the materials.

Prepared for application of the Program's cluster strategy

USAID IHP held internal discussions about ways to support the cluster strategy, under which we will prioritize support for at least one higher-performing facility in each ZS, based on population catchment and epidemiological data. We agreed that the Tahanashi coverage model often used by the MOH will be useful in helping us understand the types of coverage and the bottlenecks that each intervention should address. We will support model centers—those with exemplary performance that can serve as sources of emulation for other health centers. We will not, however, provide excessive resources, because that would make it impossible to transfer these health centers' successes elsewhere. Instead we will foster greater visibility for intangibles such as motivation, team spirit, creativity, a sense of leadership, value-based management, and results-orientation.

IR 2.2: INCREASED AVAILABILITY OF QUALITY, INTEGRATED COMMUNITY-BASED HEALTH SERVICES

We conducted limited activities under this intermediate result during FY2018. We made preliminary lists of existing services, their location, and their results. This preparatory work feeds into our overall approach for developing data systems to drive decisions. Once our provincial teams are on board, we will intensify these activities.

IR 2.3: IMPROVED REFERRAL SYSTEM FROM COMMUNITY-BASED PLATFORMS TO HEALTH CENTERS AND REFERENCE HOSPITALS

The Program has not yet undertaken any specific activities to address this intermediate result. In the coming year we will commence work with some of the DPSs and ZSs to begin to understand the challenges facing referral activities.

IR 2.4: IMPROVED HEALTH PROVIDER ATTITUDES AND INTERPERSONAL SKILLS AT FACILITY AND COMMUNITY LEVELS

There is extensive documentation of the problems faced by patients and clients, which we are incorporating into activities linked to our gender analysis and implementation strategy (see section 7.1). As part of the PICAL assessments and other activities planned in FY2019, provider attitudes and interpersonal skills will be a topic of intervention. Under our organizational capacity development approach, these attitudes are a key element in successful service delivery; we will incorporate this work into our interventions with DPS and ZS personnel.

IR 2.5: INCREASED AVAILABILITY OF INNOVATIVE FINANCING APPROACHES

Explored potential approaches for supporting health care financing

To support this intermediate result we discussed health care financing with faculty from the Kinshasa School of Public Health, studied the draft financing policy, engaged with the MOH to learn about its vision for universal health coverage, talked with experts collaborating with World Bank-financed *Projet de Développement du Système de Santé*. In particular, we focused on identifying health financing initiatives that might benefit from short-term technical assistance, since USAID IHP at this time has no health financing specialists on the team. We are drafting a preliminary scope of work for an Abt health financing expert to undertake an initial assignment, which we will submit to USAID in early FY2019.

IR 2.6: IMPROVED BASIC FACILITY INFRASTRUCTURE AND EQUIPMENT TO ENSURE QUALITY SERVICES

Engaged with the MOH about a mechanism for facilities to access funds for improvements

Our initial activities under this intermediate result centered on ways to enrich data that already exist within the health system by incorporating accurate information about infrastructure and equipment needs. A few MOH experts are promoting the concept of a *Carte Sanitaire*—a way to map with great

precision all health structures and their relevant information. It would facilitate system-level (rather than ad-hoc) mapping of the infrastructure and equipment needs of institutions at different levels. USAID IHP's data experts will support this initiative if it is adopted by the MOH.

IR 2.7: STRENGTHENED COLLABORATION BETWEEN CENTRAL AND DECENTRALIZED LEVELS THROUGH SHARING OF BEST PRACTICES AND CONTRIBUTIONS TO POLICY DIALOGUE

Strengthened collaboration and information-sharing at the national level

This intermediate result was a high priority as USAID IHP approached transition activities with IHPplus. Our philosophy is that partners need to be steered by the MOH; plans to ensure the continuity of partners with similar funding should come first from the Ministry and not only from donors. We organized the transition workshop to address several objectives simultaneously: first, a formal hand-over of approaches; next, an in-depth review of best practices; and finally a high-level debate among experts about key approaches that are relevant given the MOH's focus on very high impact interventions to reduce unacceptably high levels of maternal mortality.

5. OBJECTIVE 3:

INCREASE ADOPTION OF HEALTHY BEHAVIORS, INCLUDING USE OF HEALTH SERVICES, IN TARGET HEALTH ZONES

5.1. CONTEXT

Conflict, insecurity, and structural barriers to access to services—such as distance and lack of adequate road infrastructure and means of transport—have had a negative impact on health indicators, including MNCH, family planning, and malaria. Pervasive negative gender and cultural norms exacerbate the situation, hindering the use of health services and perpetuating unhealthy behaviors. Other behavioral factors also play a role, including low awareness of the availability of health services among the population and limited community involvement in holding health facilities accountable for their services or in providing alternative means of health care services at the community level.

5.2. ACTIVITIES IMPLEMENTED DURING THE YEAR

Our work under this objective centered on coordinating our approach with the approach of Breakthrough Action, since we have complementary roles in supporting the Minister of Health's attempts to influence the health-seeking behaviors of 30 million people. We held initial discussions with Breakthrough Action in July, following up with more detail as we developed the work plan. Our Social and Behavior Change (SBC) Advisor has met with several of our subcontractor partners, including Viamo and Matchboxology, that are engaged in behavior change activities to define upcoming activities for the new work plan year.

IR 3.1: INCREASED PRACTICE OF PRIORITY HEALTHY BEHAVIORS AT THE INDIVIDUAL, HOUSEHOLD, AND COMMUNITY LEVELS

As we carried out preliminary research to identify behaviors linked with specific health problems, we made it a priority to understand the roles of conflict and gender and the different variables at play in the different regions. We sought direct contacts with the MOH's *Programme National de Communication pour la Promotion de la Santé* to identify the materials, tools, and strategies that USAID IHP will support in the coming years. Through our conflict sensitivity report (see section 7.2) and the workshops our consultants held in each region, we were able to identify a number of attitudes and behaviors—some specific to locations and situations and some very generally held or practiced. This understanding provides a foundation for thinking through audience segmentation and ways to tailor messaging as we work with the MOH and the DPSs to establish priority messaging. The gender analysis and implementation strategy we are conducting (see section 7.1) has similar findings related to barriers to health due to gender inequality and attitudes. As we identify more specific priority messages (for example, around the use of long-lasting insecticide-treated nets [LLINs]), we will work with Breakthrough Action and our own USAID IHP resources to better understand the factors impeding adoption of these nets and the messaging media that will best improve their use.

IR 3.2: INCREASED USE OF FACILITY- AND COMMUNITY-BASED HEALTH SERVICES

To successfully undertake work under this intermediate result, we need to understand the integrated nature of community involvement and develop ways to facilitate it at scale. In addition to coordinating with Breakthrough Action, we will use techniques such as human-centered design (HCD) and cell phone messaging programs to customize our approaches. We will incorporate gender considerations throughout.

Developed guidelines for HCD integration activities

To prepare for HCD integration activities under Objective 3, USAID IHP conducted preliminary desk research and developed guidelines for integration interviews. We also started developing the HCD integration mechanism that will allow IHP implementers, the government, and partners to incorporate HCD-driven solutions into activities (see box). Our approach focuses on service provision and health-seeking behavior in malaria, MNCH, nutrition, reproductive health and family planning, tuberculosis, and WASH.

IR 3.3: REDUCED SOCIO-CULTURAL BARRIERS TO THE USE OF HEALTH SERVICES AND THE PRACTICE OF KEY HEALTHY BEHAVIORS

USAID IHP prepared for work under this intermediate result by initiating a gender analysis and implementation strategy (see section 7.1) and completing a conflict sensitivity analysis and strategy (see section 7.2).

Prepared for mobile surveys to measure socio-cultural barriers to access to care

The Program began planning work on two mobile surveys that will provide information about socio-cultural barriers Congolese citizens face when accessing health care. We will launch the surveys in November 2018 using random direct dialing. We had originally anticipated using an appointment reminder system to increase care adherence among beneficiaries. However, during the USAID IHP work planning meeting, it became evident that using an mReferral tracker system to help RECOs manage internal referrals (i.e., from health centers to hospitals) would be more beneficial to achieving intermediary result 2.3 (Improved referral system from community-based platforms to health centers and reference hospitals). We are revising our plan accordingly.

The work planning session also helped us clarify and refine other survey and SBC outreach methodologies. These include adding fraud education messages and feedback from subcontractor Geopoll surveys on community concerns to the fraud and complaints hotline (Year 2); adding push SMS to improve the coordination of quarterly meetings for the health sector (Year 1); creating audio job aids for RECOs on integrated community case management and interpersonal communications (Year 1); and adding gamified content as well as radio dramas for the Healthy Family Campaigns (Year 1).

IR 3.4: STRENGTHENED COLLABORATION BETWEEN CENTRAL AND DECENTRALIZED LEVELS THROUGH SHARING OF BEST PRACTICES AND CONTRIBUTIONS TO POLICY DIALOGUE

The Program has not yet undertaken any activities under this intermediate result.

What is human-centered design?

HCD puts human beings at the center of all challenges and opportunities. By understanding real needs and desires and uncovering deeper insights that feed into the development of programs, systems, and communication, HCD generates solutions based in reality. HCD increases the effectiveness of program adoption and implementation by government departments, partnership teams, community workers, district leaders, local program managers, policymakers, and funders.

6. TECHNICAL AREAS OVERVIEW

USAID's design of USAID IHP includes mandates in specific health service delivery areas that are essential to improving the health of the population and that have major impacts on health indicators, especially for women and children. The funding sources for USAID IHP emanate from these six key areas of health services: malaria, MNCH, nutrition, reproductive health and family planning, tuberculosis, and WASH. With this in mind, this section of the report gives a summary overview of activities and approaches for each of these technical areas. While for most of these topics specific activities beyond planning have not yet occurred during the first four months of USAID IHP, in future reports the summaries will contain updated information on programmatic actions taken, challenges, and highlights.

As we developed our work plan and shaped our Year 1 strategy for all technical areas, USAID IHP obtained guidance and input from USAID technical experts. Our goal was to ensure that we were fully integrating our technical strategies and planned activities with USAID priorities and with other programs. We also, of course, consulted extensively with the MOH and GDRC institutions, as our entire approach for these technical areas is designed to support government priorities.

6.1. MALARIA

CONTEXT

Malaria remains a leading cause of morbidity and mortality in the DRC. Highly prevalent, it continues to account for more than 40 percent of cases of infant mortality, according to the PNDS 2016–2020. Two documents contain relevant GDRC policies and strategies: the *Stratégie de Renforcement du Système de Santé* and the PNDS 2016–2020. The PNDS 2016–2020 has opted for universal coverage and scale-up of the main interventions in the fight against malaria, including those related to prevention, such as LLINs and intermittent preventive treatment in pregnancy (IPTp), as well as case management of malaria. The PNDS 2016–2020 also emphasizes the need for malaria rapid diagnostic tests and Artemisinin-based combination therapy (ACT) to cover all high-risk populations to help positively impact malaria morbidity and mortality.

Guided by GDRC priorities, USAID IHP will sustain efforts made under IHPplus, the President's Malaria Initiative (PMI) Expansion Project, and MalariaCare. Activities will take place in all 178 ZSs and will include distribution of LLINs to fully immunized children, IPTp, health center- or hospital-based management of simple and severe cases of malaria, and case management of malaria at the community level. We will also build the capacity of health providers to deliver malaria-related care, targeting 15 percent of ZSs during Year 1. These 29 zones are in Haut-Katanga (4), Haut-Lomami (3), Kasai-Central (4), Kasai-Oriental (3), Lomami (3), Lualaba (2), Sankuru (3), Sud-Kivu (5), and Tanganyika (2).

ACTIVITIES IMPLEMENTED DURING THE YEAR

Initiated collaboration with the MEASURE Evaluation IV Project

During meetings with MEASURE Evaluation, we gathered information on the need to follow up on training already done by that project and IHPplus in 78 ZSs. We also discussed coordinating USAID IHP's and MEASURE Evaluation's malaria-related M&E efforts with the DHIS2 platform's data collection, data management, and data use practices, as well as the need to support and strengthen DHIS2's capacity to collect and manage malaria-related data.

Engaged in planning and coordination with Impact Malaria

We met with Impact Malaria to share information, focusing on integrated supervision in our target provinces. USAID IHP attended a September 26, 2018, business planning workshop organized by Impact Malaria, where we were able to coordinate malaria program planning with different USAID partners.

Coordinated with the *Programme National de Lutte Contre le Paludisme* and partners on integrated supervision in USAID IHP-assisted ZSs

On September 13, 2018, USAID IHP began attending regular coordination meetings held by the *Programme National de Lutte Contre le Paludisme* (PNLP). These meetings target technical and financial partners. The September 13, 2018, meeting focused on the Roll Back Malaria partnership’s “Initiative Ten on One;” the study of 2018 entomological sites; and ways to streamline principal activities in collaboration with PMI in ZSs formerly supported by the Global Fund.

Facilitated training development for PNL

USAID IHP’s Malaria Advisor participated in the 7th International Malaria Training Course in Kinshasa on July 20, 2018, which was organized by PNL in collaboration with the University of Kinshasa. Thirty participants from 26 provinces and the central-level MOH attended this event. The Program’s Malaria Advisor delivered training and facilitated the development of a training module on strategic and operational planning. During the session we learned that the *Médecins Chefs de Zone de Santé* often do not know how to correctly estimate their achievements in reducing morbidity and mortality, or understand how to align their programs with national policies and guidelines. Therefore, the development of such skills will be part of competency-based training in USAID IHP-supported provinces.

6.2. MATERNAL, NEONATAL, AND CHILD HEALTH

CONTEXT

The DRC has one of the highest rates of maternal mortality worldwide, despite the country’s overall focus on accelerating reductions in maternal mortality. The 2013–2014 Demographic Health Survey (DHS) figures are daunting. They tell us that every hour at least two women in the DRC die giving birth, for a rate of 845 deaths for every 100,000 live births. Regardless of cause, the reported rate of maternal mortality does not reflect the actual situation in the DRC. Cases are certainly under-reported, thanks to difficulties in instituting effective oversight of maternal deaths, especially pertaining to identification, notification, analysis, and response. In addition, the statistics on neonatal mortality (28 out of every 1,000 live births) and childhood mortality (104 out of every 1,000 live births) remain high, indicating that children still die in large numbers from known and easily preventable causes despite years-long efforts to improve neonatal health interventions and address childhood illnesses.

ACTIVITIES IMPLEMENTED DURING THE YEAR

In mid-September USAID IHP participated in the regular coordination meetings for the *Prise en Charge Intégrée de la Maladie du Nouveau-né et de l’Enfant* of the MOH. These meetings focus on monitoring the implementation of national-level recommendations, and their content is of cardinal importance for the Program. As we prepared the work plan, we focused in particular on priority interventions or packages that are fully in line with recent priorities set by the MOH in the reframed PNDS 2019–2022 and with USAID’s programmatic priorities.

Coordinated technical strategy with a roadmap developed by the *Programme National de Santé de la Reproduction*

In September, the *Programme National de Santé de la Reproduction* organized a workshop to develop a roadmap to reduce maternal mortality during the 2018–2022 period. USAID IHP joined the different national level partners in this endeavor. These collaborations will be of vital importance because the Program will be a prime partner for provinces as we help them tackle this complex public health problem. The list of workshop participants reflects the range of partnerships that various USAID IHP advisors will cultivate in the near future. They include the *Direction des Groupes Spécifiques et de Familles*, the DGOSS, the *Programme National des Infections Respiratoires Aiguës*, the PNL, PRONANUT, and the *Programme National de Lutte contre le Sida*. International partners such as UNICEF, the World Health Organization (WHO), and the UNFPA are also part of this coalition.

The outcome of this workshop was the creation of a new coalition—the *Comité Multi-sectoriel de Lutte Contre le Décès Maternel*—that needs to be replicated at the provincial level. USAID IHP has committed itself to fully supporting this approach and to applying it in particular in provinces where mortality is highest, such as Sud Kivu (361 deaths during the first semester of 2018), Haut Lomami (245 deaths during the first semester of 2018), and Tanganyika (180 deaths during the first semester of 2018) (Bulletin N° 1 SDMR 2018).

6.3. NUTRITION

CONTEXT

Several DRC policy and strategy documents demonstrate the importance of nutrition as a public health problem and show its persistence as an extremely complex problem for which no simple remedies exist. These policies and documents include the National Nutrition Policies of 2000 and of 2013, the *Plan Stratégique Multi-sectoriel de la Nutrition 2016–2020*; and the *Plan National Stratégique Multi-sectoriel de la Nutrition 2015–2020*. USAID IHP's strategy for nutrition was developed in line with these GDRC strategies and after consultations with PRONANUT. We will work in health facilities and at the community level to introduce nutrition activities (especially behavior change campaigns) and also incorporating nutrition activities as part of the package of care, with the aim of including the promotion of proper nutrition and the detection, prevention, and treatment of malnutrition among women and children under the age 5. Within the overall framework of USAID IHP's mandate to strengthen institutions and communities, we will support DPSs and ECZSs to increase the availability of essential facility-based health services and strengthen the capacity of RECOs to detect, treat, and prevent malnutrition in communities.

ACTIVITIES IMPLEMENTED DURING THE YEAR

Coordinated USAID IHP activities with Food for Peace

The Eastern Congo Regional Director met with Food for Peace to talk about ways to ensure synergy between that program and USAID IHP's nutrition activities. We agreed to hold quarterly meetings with rotating leadership to harmonize our work plans, share survey data and other data, include UNICEF in our joint exchanges, and join together to support the DPSs and ZSs as they develop and implement their PAOs.

6.4. REPRODUCTIVE HEALTH AND FAMILY PLANNING

CONTEXT

The DRC's population of 85 million is growing at an annual rate of 3.28 percent (World Population Review - 2018). Within the country, there are differences in fertility, creating the need for province-

specific interventions to address norms, beliefs, and behaviors; health service availability and quality; and use of health services. Good family planning services as well can help reduce maternal and child mortality. Currently, the use of modern methods of contraception in the DRC is low, at about 8.1 percent nationally. This is due in part to a 28 percent gap between supply and demand for family planning supplies, according to the DHS 2013–2014. The DHS 2013–2014 showed a low adoption rate (3.5 percent) for family planning methods in Katanga province. However, because the survey was done before decentralization, the configuration of provinces was different than the one USAID IHP is working within.⁴ In Lualaba, the DPS has more recent data, which show that the rate of adoption of family planning methods has risen dramatically—to 16 percent—thanks primarily to work done in that province by Pathfinder and IHPplus with USAID support. Current data are not available for other provinces.

ACTIVITIES IMPLEMENTED DURING THE YEAR

Participated in the Third Annual Kolwezi Mining Conference

USAID IHP attended this September 12–14, 2018, conference, which focused on domestic resource mobilization and the implications of this mobilization on the private sector. Mining companies and civil society organizations created a *Comité Technique Multi-sectoriel et Permanent pour la Planification Familiale*, which now advocates for the mobilization of comprehensive family planning resources. It targets the highest levels of government, including the Office of the President, the Governor of Lualaba, and province- and national-level ministers, as well as mining companies. The Program is committed to this process and will engage with these actors and other partners as we implement our reproductive health and family planning agenda.

Attended World Contraception Day advocacy campaign event in Kasai-Central

On September 26, 2018, the USAID IHP Kasai Regional Director joined other partners and stakeholders in supporting this important province-level advocacy event in Kasai-Central. He used the opportunity to meet with the heads of the DPS and IPS, two key partners for the Program's future office in that province.

6.5. TUBERCULOSIS

CONTEXT

The DRC is one of the 30 countries with highest TB burden and one of the four countries in the WHO's Africa Region that are most affected by drug-resistant TB. About half of the TB cases projected annually are not detected. The TB problem in the DRC is exacerbated by the existence of TB-HIV co-infections and by the appearance of strains of bacilli resistant to first-line and second-line anti-TB drugs.

Together with other technical and financial partners, USAID IHP is working in the spirit of the rationalization efforts pursued by the MOH. We will continue to conduct catalytic activities in Haut-Katanga that were formerly supported by the Global Fund. These activities identify unreported cases and deliver innovative interventions for screening, diagnosis, and treatment among special populations, such as prisoners, miners, or children.

⁴ What was Katanga province at the time of the DHS 2013–2014 survey is now four separate provinces: Haut-Katanga, Haut-Lomami, Lualaba, and Tanganyika.

USAID IHP is collaborating with Challenge TB to provide a TB services package in the five provinces where Challenge TB already works, noting that part of our contribution is to work closely with the ZSs and DPSs to ensure that these activities are included as part of their service delivery programming. We will support 30 percent of the ZSs in those provinces (Kasaï-Central, Kasaï-Oriental, Lomami, Sankuru, and Sud-Kivu). In the four other provinces (Haut-Katanga, Haut-Lomami, Lualaba, and Tanganyika), our activities will complement those of *Action Damien*. We will support 30 percent of ZSs in these provinces as well, although the ZSs have not yet been selected. USAID IHP activities will include strengthening the *Centres de Santé de Détection et de Traitement* and increasing their geographical coverage, working toward targets set at the national level; transporting samples; intensifying screening among special and vulnerable groups and among children; and collaborating with civil society organizations and the *Club des Amis Damien* to reach those target groups.

ACTIVITIES IMPLEMENTED DURING THE YEAR

Participated in the review of the *Programme National de Lutte contre la Tuberculose*

USAID IHP participated in the 22nd annual review of the *Programme National de Lutte contre la Tuberculose* (PNLT) from August 27 to September 9 in Matadi in Kongo-Central province. This gave us the opportunity to introduce USAID IHP to TB stakeholders and TB experts from the MOH and to be fully informed about PNLT strategies in our nine target provinces. We engaged in interesting discussions about rationalizing resources for good governance in partner interventions.

Engaged with other partners supporting TB programming

As part of our detailed work plan preparation, we held discussions with the USAID Mission's TB focal person, along with representatives of Challenge TB. These meetings provided key information on priorities, expectations, and technical guidelines and ensured that USAID IHP's TB intervention strategy is fully complementary with other partner interventions.

6.6. WATER, SANITATION, AND HYGIENE

CONTEXT

Policy documents on WASH are less abundant than for other health programs. While a Water Act was published in January 2016, other water-related policies and implementation measures are still in draft stages. The Water Act states that in rural and peri-urban areas the public water service can be managed by an association of users with legal personality in accordance with this law. A law on hygiene and sanitation is in draft and has not yet been adopted by parliament. This law would require drinking water to meet regulatory standards for health and potability. The PNDS 2016–2020 is also important for WASH. It mentions strengthening the *Comité National de l'Action de l'Eau, l'Hygiène et l'Assainissement* and expanding it into the provinces. WASH is also planned as part of the implementation of high-impact interventions under the reframed PNDS 2019–2022.

USAID IHP's WASH technical area contributes to the achievement of Objectives 2 and 3. Its purpose is twofold: 1) to improve consistent access to clean, healthy water in target communities; and 2) to promote good hygienic practices in health facilities and communities to reduce the likelihood of contracting illness related to lack of access to clean and sanitary water.

During Year I, WASH activities are slated to take place across 10 ZSs, mostly in Kasaï and Sud-Kivu. Due to the prevalence of cholera outbreaks in these areas, our activities will focus primarily on establishing or reestablishing access to clean water supplies, toilets, and hand-washing stations in health facilities and communities. We will also conduct WASH needs analyses and surveys in six provinces: Haut-Katanga, Kasaï-Central, Kasaï-Oriental, Lomami, and Sud-Kivu,

ACTIVITIES IMPLEMENTED DURING THE YEAR

Developed a clear and simple implementation strategy for WASH activities

Because USAID IHP's WASH funds are not sufficient to cover all of the Program's target ZSs, we must prioritize our activities from Year 1 onwards. We engaged in intense consultations among all USAID IHP advisors across technical areas and with MOH counterparts and other partner organizations. This enabled us to ensure that the foundations of our community-based WASH activities are properly anchored in participatory and development approaches that put communities at the center, focusing in particular on their mobilization capacity around community-based activities such as access to clean water.

As a result we were able to develop a clear implementation strategy: our WASH activities will be grounded in community participation and community engagement activities, in which *Cellules d'Animation Communautaire* are the primary actors rather than the CODESAs. As part of our overall health facilities renovations work (which is a very large part of the Program but does exist in the Program Work Statement) we will include WASH facility improvements as part of renovations as they are planned and if needed.

7. CROSS-CUTTING AREAS

7.1. INSTITUTIONALIZATION AND SUSTAINABILITY OF GENDER EQUALITY

CONTEXT

Gender norms impact access to health services and products, health services quality, and health-seeking behavior among women, men, and youth in USAID IHP's target regions and provinces. We recognize that gender equality and female empowerment are worthy objectives in their own right, as well as being integral to our ability to achieve USAID IHP's health system and service delivery goals. A sound gender implementation strategy will accelerate progress towards key Program results, including increases in the uptake of childhood immunization; treatment of acute childhood respiratory infections, fever, and diarrhea; uptake of antenatal care; and acceptance of modern family planning methods.

ACTIVITIES IMPLEMENTED DURING THE YEAR

Commenced gender and analysis and strategy

USAID IHP began a gender and youth assessment in September 2018 (continuing into October 2018), with the objective of developing a gender sensitivity and implementation plan to ensure that we integrate gender transformative approaches into all program interventions and activities. To complete the gender and youth assessment, we conducted a desk study and held a validation workshop in Kinshasa from September 18 to 20, 2018. Workshop participants discussed other programs' successes in implementing transformative gender approaches and responding to adolescent health needs. As FY2019 opens, we are carrying out key informant interviews and further analysis in the three regions. As part of the analysis, we:

- Analyzed social norms and legal factors that underlie gender and identity differences and the identity of youth in program areas.
- Mapped health-related gender and youth profiles in program areas.
- Assessed gender and youth among program staff to identify potential impacts, constraints, and opportunities for gender transformation.
- Furnished evidence of the most effective approaches for gender transformation as used by relevant programs.
- Prepared a plan for implementation, M&E, and learning on gender- and youth-related issues.

The report's recommendations describe gender transformative approaches that address constraints and advance opportunities based on gender norms. The gender analysis and implementation strategy will guide our work during Year I; we will update the gender implementation strategy during our annual work planning process. We will actively monitor unintended consequences from implementation. The report will be submitted to USAID on November 2, 2018.

7.2. CONFLICT SENSITIVITY

CONTEXT

Unrest, conflict, and insecurity in the three USAID IHP regions pose challenges for Program implementation. USAID IHP prepared an analysis and report to provide both USAID and the USAID IHP team with insights into the four primary types of conflicts present in our target regions and to recommend a strategy for mitigating the potential security and programmatic risks of working in conflict-affected communities.

- **Eastern Congo.** In this region, Tanganyika in particular faces a volatile security situation. For example, the Tundwa and Bendera roads remain dangerous enough that vehicles must travel in convoys, although the Moba-Lubumbashi road has been recommended by INSO. To address these problems, USAID IHP will engage in daily monitoring of staff and their whereabouts, ensuring the Program has high-quality vehicles, VHF and UHF radios, and a Security Chief; and consider placing staff permanently in Kabalo and Manono. We will also foster contacts with the UN Humanitarian Air Service and with European Civil Protection and Humanitarian Aid Operations (ECHO) flights, with support from USAID, to ensure access to air travel along certain routes in case insecurity makes road travel inadvisable.
- **Kasai.** The current security situation is relatively calm in our target areas in the Kasai region, but the situation could change quickly because a number of problems remain. These include internally displaced people (IDPs) from areas that were seriously affected by the recent civil and military conflicts; food insecurity in most areas; high unemployment rates and levels of poverty; and limited access to health care services. Humanitarian assistance is being provided by a variety of agencies (e.g., the World Food Programme, the Red Cross, Doctors without Borders, Norwegian Relief). We anticipate that USAID IHP will contribute to the ongoing relief and development efforts by working closely with target ZSs to strengthen capacity and increase access to the integrated delivery of community- and facility-based primary health care services.
- **Katanga.** For the moment, the Katanga region is stable and peaceful. There are, however, some corners of Lualaba province with conflicts between original landowners and international mining companies and conflicts between traditional landowners and migrants in search of mining opportunities. In the northeastern part of the region (Kilwa, Pueto) there are some armed groups vandalizing and attacking communities, although their leader has signed a peace accord and is working with the current government. Some politicians are using the fragile situation to try to gain power, which exacerbates tensions, especially during the 2018 election year. The situation could deteriorate if the election does not go well.

With persistent poverty and a lack of access to essential health services in our target areas, USAID IHP activities have the potential to serve as a stabilizing force and help prevent conflict by promoting community participation in integrated community-based delivery of health services and promoting the establishment of community-supported health committees to encourage dialogue and participation in health-related community development activities (e.g., WASH, malaria prevention, assisted deliveries, TB prevention, referral for management at functioning health facilities, and MNCH).

ACTIVITIES IMPLEMENTED DURING THE YEAR

Conducted conflict sensitivity analysis and developed strategy to mitigate potential risks for USAID IHP



Photo: Armand Utshudi, USAID IHP

Kazumba women's focus group, Bilomba ZS

Research and analysis. During August 2018, a USAID IHP team gathered information through a desk review and qualitative data collection in USAID IHP's three regions. We used key informant interviews to obtain primary data from individuals in specific positions within various DPSs, ZSs, and community service organizations. We also conducted focus group discussions to gather information from community members, usually separating women from men and youth from

adults so that everyone in the group would feel comfortable speaking up.

- **Eastern Congo region.** In South Kivu, we conducted several face-to-face and phone interviews with the Bagira Médecin Chef de Zone (MCZ), a representative of the DPS, and representatives of Search for Common Ground. We also relied on background information from the USAID-funded Solutions for Peace and Recovery project. In Tanganyika, we held a workshop in Kalémie on August 9, 2018, with representatives from the DPS, the Kalémie *Bureau Centrale de la Zone* (BCZ), the Nyemba BCZ, Food for the Hungry, the *Commission Diocésaine Justice et Paix*, and Search for Common Ground.
- **Kasai region.** We coordinated key informant interviews and focus group discussions from August 13–18, 2018, in Kasai-Central, Lomami, and Sankuru with representatives from DPSs, the MCZ, health providers, local authorities (*Administrateur de Territoire*), community leaders, CSO representatives, and women.
- **Katanga region.** We held information-gathering workshops in Haut-Katanga, Haut-Lomami, and Lualaba from August 12–21, 2018.

Consolidation workshop. USAID IHP held a five-day conflict sensitivity workshop in Bukavu, Sud-Kivu, from August 20–24, 2018. Facilitated by IR, the workshop tapped into participants’ contextual knowledge through a series of conflict analysis and Do No Harm (DNH) exercises. These included a conflict mapping exercise, a connectors and dividers exercise, and a scenario planning exercise. Participants identified risks and opportunities for USAID IHP and discussed recommendations for Program implementation, focusing on all aspects of programming and management, including staffing, staff training, staff and partners’ behaviors, and activities.

Findings and recommendations. The risks to USAID IHP implementation are severe. Conflict and tensions can cause service delivery interruptions and create risks for both security and programming.

Some potential security risks, along with recommended mitigating actions, include:

- **Disrupted supply of services.** Potential mitigating actions include ensuring ownership of facilities by beneficiaries to prevent looting or destruction of facilities during violent conflict; communicating with beneficiaries to explain of stock-outs when insecurity prevents delivery; and ensuring well-balanced (by ethnicity, gender, age) representation on the CODESA.
- **Sudden increase or change in demand for services due to crises or lack of access by one group for fear of discrimination.** Potential mitigating actions include supporting DPSs and BCZs with contingency planning for emergencies; ensuring health staff are trained on and apply MOH standards of professional conduct; supporting DPSs and ZSs to develop strategies to recruit more female health staff; coordinating with authorities providing protection and/or humanitarian assistance in each locality; and coordinating with other programs that support gender-based violence prevention and response and mental health.
- **Need for additional or different services.** Potential mitigating actions include advocacy about the need to develop mental health strategies and to train health staff in identification, treatment, or referral of mental health conditions.
- **Lack of access by program beneficiaries due to a crisis or lack of perceived ownership of or responsibility for the facility.** Potential mitigating actions include ensuring that RECOs are trained and have supplies for emergency situations; supporting DPSs and ZSs to implement fee structures that give a majority of the population access to basic healthcare and that they apply vulnerability criteria for access to free care; establishing contact with authorities providing protection and/or humanitarian assistance; and working with DPSs and ZSs to ensure that complaints mechanisms function in each facility, including safeguards to prevent retaliation.

Some potential programmatic risks and recommended mitigation actions include:

- ***Lack of neutrality of MOH staff at the facility level during selection of CODESAs and RECOs or partiality during recruitment of BCZ and facility staff.*** Potential mitigating actions include training and coaching counterpart organizations on standards of professional conduct; supporting DPSs and ZSs to develop and display codes of conduct; and supporting the MOH to establish complaints mechanisms at the facility level.
- ***Perceived partiality in procurement or in targeting facilities for support, rehabilitation, and equipment.*** Potential mitigating actions include ensuring transparent, professional procurement processes; purchasing small supplies locally when possible; ensuring each facility has a functioning complaints mechanism; and creating and using a Security Management Strategy of Community Acceptance.
- ***Lack of access or availability of services.*** Potential mitigating actions include informing representatives of all groups in the conflict area about the definition of indigence criteria and ensuring that health staff and RECOs are informed and apply the policy on free healthcare for IDPs.

Implementation strategy. The outcome of the analysis and workshop led to the creation of an implementation strategy that fed into our Year I work plan and guided the creation of appropriate planning and M&E tools. As a result of the conflict sensitivity analysis and planning, USAID IHP will take the following steps:

- Develop role descriptions for DNH focal points. These focal points will have authority and efficient communication access to Program management to raise alerts about conflict-related issues and to recommend changes to procedures and approaches. To the extent possible, USAID IHP will ensure strong female representation among these focal points.
- Designate and train DNH focal points on conflict sensitivity analysis, DNH, and gender-related issues.
- Conduct the next set of awareness and implementation workshops when a majority of staff is on board. This will enable us to develop staff capacity to understand the conflict contexts in which they are operating and to develop and apply strategies to work within and improve MOH service delivery operations within these contexts.

USAID IHP will closely monitor the situation in all provinces, wherever it remains volatile. We may use vehicles with USAID logos to identify our staff. In addition, our vehicles will have GPS and tracking devices. We will avoid trips in unstable areas until peace can be ascertained. We will train RECOs to manage emergency kits so they can continue providing services in case of open conflict. Throughout, the Program will work in synergy with other international technical and financial partners to create a conducive environment for peaceful conflict resolution.

7.3. CAPACITY BUILDING

ACTIVITIES IMPLEMENTED DURING THE YEAR

USAID IHP has a variety of organizational capacity development and personnel capacity development mandates as part of its program. A key objective is the capacity development of the DPSs and ZSs and supportive organizations (*Cellules d'Animation Communautaire*, health facilities, CODESAs) to fulfill their functions and carry out the systems activities that are required for them to operate and account for their activities. Alongside this need for organizational capacity development is the need for individual development of personnel in all of these organizations. This is true from the point of view of both technical knowledge and perspectives and attitudes (intangibles), to make them more capable of and

committed to carrying out their assigned functions. These are two different programmatic thrusts as developed and described in the Capacity Development Approach report submitted to USAID on October 5, 2018.

A key element of the approach, especially for the organizational development program and our Objective I mandate, is to carry out the PICAL self-assessment tool at the DPS, ZS, and even community levels to ascertain areas of weakness and identify focus areas for capacity improvement. Using a variety of tactics, such as coaching, accompanied programming, on-the-job training, cascade training, and training-of-trainers programs, we will work with these various stakeholders to help them identify areas where changes in behaviors and increased knowledge of their tasks can improve their operations and service delivery, increase their job satisfaction, and improved incentives for staff to carry out their jobs.

7.4. PRIVATE SECTOR

CONTEXT

The private health sector is an important player in the health system of the DRC, but the extent of its contribution remains very little known. Private providers, especially faith-based organizations, experienced a boom at the end of the 1990s and early 2000s to fill the gaps during a period when the public health sector was weakened. The government has recognized the importance of private providers and decided to integrate them across the health care system—the private sector is now mentioned as a key partner in several MOH strategies, policies, and plans. However, public-private cooperation for health is still in its infancy, with the exception notable of faith-based organizations.⁵

ACTIVITIES IMPLEMENTED DURING THE YEAR

Participated in the launch of MOH report on the role of the private sector

In September 2018, the MOH launched the report of a study on the role of the private sector in improving the performance of the DRC's health sector. This yearlong study, commissioned by the Bill and Melinda Gates Foundation, the World Bank, and USAID, was debated in terms of its recommendations in April 2018. With this launch, the MOH intended to offer the different actors in the health system comprehensive insights into all the questions that could benefit from better public-private collaboration between the private sector and the health sector. Several recommendations are immediately applicable to USAID IHP context of our target provinces. This event was an opportunity to meet several key players that can become partners in the future.

7.5. CLIMATE RISK MITIGATION, ENVIRONMENTAL MITIGATION AND MONITORING

CONTEXT

USAID IHP expects the greatest environmental impacts of our Program to be from infrastructure renovations, medical and shipping waste, and travel. We have developed strategies to mitigate those

⁵ Text in this paragraph and the paragraph below on the launch of the report on the role of the private sector taken from a report published by Abt Associates. See: Brunner, Bettina, Virginie Combet, Sean Callahan, Jeanna Holtz, Emily Mangone, Jeff Barnes, Cathy Clarence, Auguste Assi, and Stephanie Gober. 2018. « Le rôle du secteur privé dans l'amélioration de la performance du système de santé en République démocratique du Congo. » Bethesda, MD: Abt Associates.

impacts, including maximizing sourcing of local materials, ensuring energy efficiency when rehabilitating facilities, establishing supply chains that maximize capture of waste materials, using drones for targeted medical deliveries, investing in increased bandwidth to maximize virtual communication, and exploring alternative modes of transportation. Where relevant to the overall MOH program (as opposed to USAID IHP office activities), USAID IHP staff will work with the MOH staff to use their systems and personnel to ensure that they comply with environmental actions, especially since these actions need to be part of their ongoing responsibilities in the future.

ACTIVITIES IMPLEMENTED DURING THE YEAR

Completed and submitted the Environment Mitigation and Monitoring Plan

USAID IHP submitted the Environmental Mitigation and Monitoring Plan (EMMP) on September 6, 2018. Environmental compliance and achieving optimal development outcomes for Program activities requires environmental management expertise. Drawing on the specialized knowledge of Abt's home office, we met with select USAID IHP staff who provided input and helped tailor the Program's EMMP to needs and realities in our target regions and provinces. After receiving feedback from USAID and approval in principle on September 19, 2018, we submitted a revised version of the EMMP on September 28, 2018.

Completed and submitted the Climate Risk Mitigation Plan

The Program conducted a climate risk assessment using resources from USAID's Climate Risk Management pilot training program, information from USAID's ClimateLinks website, and Internet resources such as USAID's DRC Climate Vulnerability Profile. We evaluated the programmatic and activity plans of USAID IHP to assess the impact that climate change and environmental factors may have on our strategies and objective, as well as their potential effects on target populations. We submitted a Climate Risk Mitigation Plan (CRMP) on September 6, 2018. After receiving feedback from USAID, we submitted a revised version on September 28, 2018, which was approved on October 25, 2018.

8. ACTIVITY RESEARCH, MONITORING, AND EVALUATION

8.1. CONTEXT

The health data ecosystem in the DRC is very fragmented, with data stored in siloed databases—the result of a long-standing vertical approach. For example, Logistics Management Information System (LMIS) data is split among multiple, non-harmonized data systems (for HIV and malaria, in the HMIS, etc.). The result is duplicate data collection processes. This practice impacts data quality and prevents a cross-sectional overview of health system information.

USAID IHP has developed an approach for our own M&E system for Program reporting that will both enable us to report on our contract targets and indicators and strengthen DRC health data systems and metrics. Our key principles include the following:

- Try to not collect data that has already been collected, since a wealth of data already exists that we can use to build USAID IHP M&E metrics (and it would be cost-prohibitive to collect independently for 140 indicators).
- Contribute to gradually strengthening country-level data by using data science techniques, since one challenge is the irregular quality and timeliness of existing data.
- Contribute to better metrics and data insights.

USAID IHP has developed a data system based on DHIS2 and in-house software products connected to DHIS2. The system draws data from existing data sources, while allowing us to enter specific types of data and manage data flexibly. Our system will facilitate data use by making M&E metrics available through a customizable dashboard for different DRC health system stakeholders, including provincial and ZS staff, as well as the USAID IHP team.

In addition, because USAID IHP is designed to be an agile, results-focused program, we will use data generated and analyzed through research, monitoring, and evaluation (RME) to develop, refine, and adapt our approaches. By adapting existing tools, systems, and services to improve efficiency, we will empower Congolese institutions and communities to deliver high-quality, integrated, and sustainable health services.

8.2. ACTIVITIES IMPLEMENTED DURING THE YEAR

Completed the Activity Monitoring and Evaluation Plan and annexes

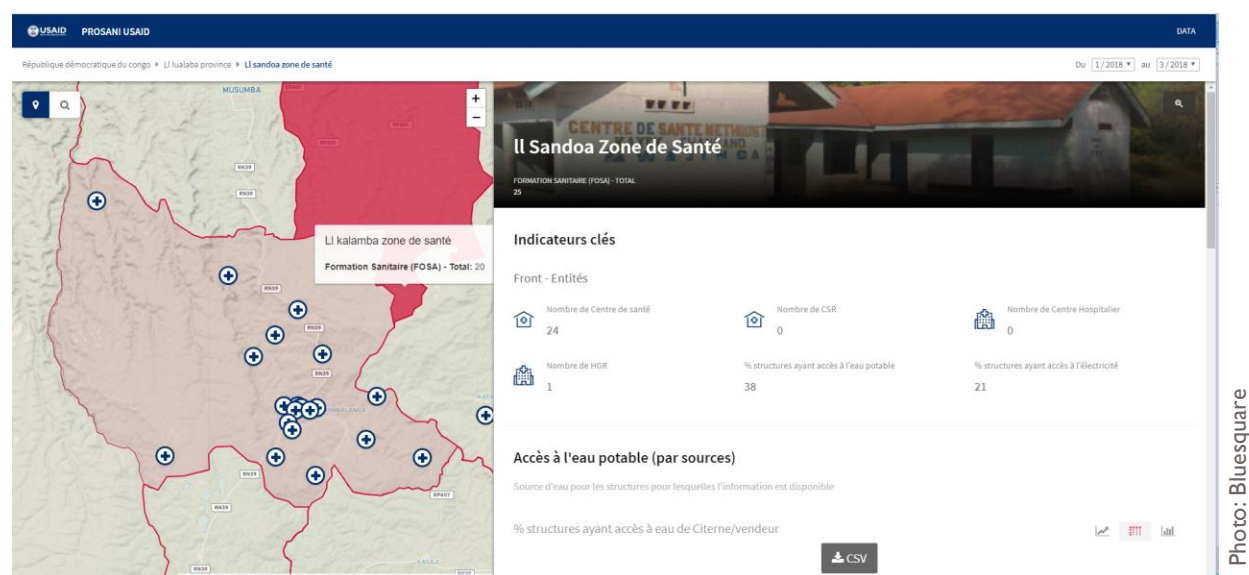
We submitted a draft AMEP to USAID on September 6, 2018. The AMEP included our results framework; monitoring, evaluation and learning strategy; CLA strategy; and illustrative research and evaluation questions. We received feedback from USAID on September 19, 2018. As of the end of the fiscal year, we were preparing a revised version, which we submitted on October 19, 2018.

The AMEP incorporates a number of annexes, including a Performance Indicator Tracking Table (PITT), Performance Indicator Reference Sheets (PIRS), and proxy indicator table for some of our fee-bearing indicators that are only reported on in the DHIS2 system at lengthy intervals over four to five years. The most recent version of the PITT (submitted to USAID on October 19, 2018) contains a comprehensive list of our indicators based on the structure of the results framework. It highlights details about our impact, outcome, and output indicators.

Developed an M&E Platform

To manage the complex RME system, USAID IHP will use a web-based, fully integrated M&E platform that will serve as a Program management tool and database. The platform will allow USAID IHP and

USAID to produce analyses and reports for decision-making based on real-time information. Given that our Program is interconnected with the HMIS system in the management and monitoring of some indicators, we requested and obtained access to DHIS2 for all technical staff and for Bluesquare, our M&E database subcontractor (which is also providing direct assistance to the MOH for its own reporting and dashboard functions). Our USAID IHP M&E platform will inform the design of the MOH Performance Dashboard that we are co-designing with the GDRC in coming months.



Sample page from dashboard from the draft USAID IHP M&E platform.

Photo: Bluesquare

Commenced mapping USAID IHP M&E indicators with HMIS data

USAID IHP is mapping existing data in the DHIS2 against USAID IHP key performance indicators and reporting needs. Using different sources of data as an example for the template to present to USAID, Bluesquare developed algorithms to support alignment of different health facility data sources. This included importing the following attributes: population, access to water and electricity, GPS codes, facility type (health center, hospital, etc.), and ownership (public, private, etc.). By combining different data sources, we have identified 5,967 health facilities. So far, we have GPS coordinates for only 1,861 of those and information about access to water and electricity for only 501 of them.

As of the end of FY2018, few key USAID IHP performance indicators had been selected and mapped with existing HMIS data as part of a demonstration process for USAID reporting (those chosen include acute respiratory infection, TB, DTP3 vaccines, 4th antenatal care visit, stock-outs, malnutrition). Our team identified 420 data elements as being valuable for USAID IHP's M&E efforts, 36 data elements as valuable for health services, and 384 data elements as valuable for LMIS. Since program inception, we have loaded five million data values into the USAID IHP database. The process for the USAID M&E reporting database is to use a combination of existing MOH data from DHIS2 and other databases plus customized data sources from our own USAID IHP surveys and data collection efforts to meet the Program's indicator reporting needs.

Prepared for a baseline household survey

Some indicators proposed in the AMEP will have to be collected from household surveys. To accomplish this, USAID IHP is designing a household survey that will be outsourced to a research firm in our target provinces. On September 20, 2018, we prepared a concept note identifying all of the indicators that

must be included in the survey. We created a rough overview of the expected study methodology and estimated sample sizes. We also developed a terms of reference and templates to guide a competitive procurement for a research firm. This document is in the process of being revised and will be advertised as a request for proposals in the coming weeks.

ANNEX A: PERFORMANCE INDICATORS, TARGETS, AND ACHIEVEMENTS

We submitted a revised version of the Performance Indicator Tracking Table on October 19, 2018. We are awaiting USAID feedback. As soon as we receive formal approval, we will begin the baseline data collection process, propose and establish targets with USAID, and begin formal M&E activities that will inform future reports.

ANNEX B: SUCCESS STORIES

Given that USAID IHP was operation for only four months during FY2018 and that this period focused heavily on start-up, relationship-building, analysis, and planning, we do not yet have any success stories to report.

ANNEX C: DELIVERABLES SUBMITTED IN FY 2018

Deliverable	Submitted	Comments
Mobilization Plan	July 2, 2018	Submitted and approved.
Branding Implementation Plan	July 24, 2018	Submitted and approved.
Express Safety and Security Contingency Plan	July 30, 2018	Submitted and acknowledged.
Quarterly Report, FY2018 Q3 (April–June 2018), including French and English summaries	August 9, 2108	Submitted and approved.
Annual Work Plan, Year I	August 31, 2018 (original); October 19, 2018 (revision)	Submitted, USAID feedback received, revised version submitted.
Climate Risk Mitigation Plan (CRMP)	September 6, 2018 (original); September 28, 2018 (revision)	Submitted, USAID feedback received, revised version submitted.
Environment Mitigation and Monitoring Plan (EMMP)	September 6, 2018 (original); September 28, 2018 (revision)	Submitted, USAID feedback received, revised version submitted.
Activity Monitoring and Evaluation Plan (AMEP)	September 6, 2018 (original); October 19, 2018 (revision)	Submitted, USAID feedback received, revised version submitted.
Program Management Plan (PMP)	September 6, 2018 (original); October 19, 2018 (revision)	Submitted, USAID feedback received; revised version submitted.
Conflict Sensitivity Analysis and Gender Implementation Strategy	September 6, 2018 (original); October 11, 2018 (revision)	Submitted, USAID feedback received (9/26), revised version submitted.
Updated Procurement Plan	September 6, 2018 (original); October 19, 2018 (revision)	Submitted, revised version submitted with revised work plan.

ANNEX D: SIGNIFICANT MEETINGS, FY2018

Meeting	Dates	Participants and Purpose
Post Award Kick-off Meeting with USAID	June 5, 2018	<i>Participants:</i> USAID, Abt management, COP <i>Purpose:</i> Introduce USAID and Program team and provide guidance to Abt management for start-up and contractual issues
Meeting with Acting USAID Mission Director	July 24, 2018	<i>Participants:</i> Abt Portfolio Manager, USAID IHP COP, Deputy COP <i>Purpose:</i> Courtesy visit to introduce Abt Associates and COP
Meeting with Chargé d’Affaires of U.S. Embassy	August 2, 2018	<i>Participants:</i> USAID IHP COP, VectorLink COP, USAID Acting Health Office Director, GHSC-TA COP <i>Purpose:</i> Courtesy visit to introduce various programs
Preparation for work planning workshop Work planning workshop	Preparation: June 5–July 26, 2018 Workshop: Jul 23–27, 2018	<i>Participants:</i> USAID IHP staff, subcontractors, USAID representatives <i>Purpose:</i> Program orientation and team building
Preparation for meetings with MOH	July 30, 2018–ongoing	<i>Participants:</i> Acting Mission Director, Health Office Director, USAID technical staff, Abt <i>Purpose:</i> Prepare for MOH meetings
Meeting with Minister of Health	August 13, 2018	<i>Participants:</i> USAID Health Office Director, USAID technical staff, USAID IHP COP and Deputy COP <i>Purpose:</i> Introduce USAID IHP to Minister, provide overview, describe objectives
Meeting with MOH Secretary General	August 21, 2018	<i>Participants:</i> USAID Health Office Director, USAID IHP COP and Deputy COP <i>Purpose:</i> Introduce USAID IHP, provide overview, describe objectives,
Meeting with MOH <i>Directeur Général</i> de DGOGSS	August 28, 2018	<i>Participants:</i> <i>Directeur Général</i> de DGOGSS, DGOGSS Advisors, USAID IHP COP and Deputy COP <i>Purpose:</i> Introduce USAID IHP, provide overview, engage in discussion about partnership and collaboration
Meetings with USAID program partners	Beginning July 16, 2018 ongoing	<i>Participants:</i> IGA, Breakthrough Action, GHSC-TA, IHPplus, MEASURE Evaluation <i>Purpose:</i> Ensure complementarity and leverage resources toward common goals
Meeting with IHPplus COP	July 31, 2018	<i>Participants:</i> IHPplus COP and staff, USAID IHP COP and Deputy COP <i>Purpose:</i> Organize transition

Meeting	Dates	Participants and Purpose
Meetings with IHPplus team	August 1, 2018 and subsequent meetings	<i>Participants:</i> MOH, USAID IHP team, IHPplus team <i>Purpose:</i> Discuss transition workshop to transfer lessons learned from IHPplus to USAID IHP team, under leadership of MOH; prepare for workshop
Lessons Learned and Actions to be Taken Workshop	August 23, 2018	<i>Participants:</i> MOH, USAID IHP team, IHPplus, USAID <i>Purpose:</i> Transfer lessons learned from IHPplus
Preparation for conflict sensitivity report	Various dates, August 2018	<i>Participants:</i> IRC, GDRC representatives and beneficiaries in Eastern Congo, Kasai, and Katanga <i>Purpose:</i> Gather research, hold interviews and workshops to prepare conflict sensitivity analysis and implementation strategy
Preparation for gender analysis and gender implementation strategy	Various dates, August–September 2018	<i>Participants:</i> Pathfinder, GDRC representatives and beneficiaries <i>Purpose:</i> Prepare, conduct research, interviews, and workshop to prepare and research the report
Meetings to prepare USAID IHP M&E systems	Various dates, August–September 2018	<i>Participants:</i> Bluesquare, USAID RME team <i>Purpose:</i> Construct database for data collection and reporting of USAID IHP M&E data
Courtesy visits of USAID IHP Regional Directors in their locations with MOH DPS officials	Various dates, August–September 2018	<i>Participants:</i> USAID IHP Regional Directors, MOH officials, <i>Chefs de DPS</i> in Eastern Congo, Kasai, and Katanga <i>Purpose:</i> Courtesy visits with DPS counterparts (following MOH approval)

ANNEX E: ENVIRONMENTAL MITIGATION AND MONITORING REPORT

PROJECT/ACTIVITY DATA

Project/Activity Name:	USAID's Integrated Health Program (USAID IHP)
Geographic Location(s) (Country/Region):	Democratic Republic of the Congo
Implementation Start/End Date:	January 31, 2018-May 29, 2025 ⁶
Contract/Award Number:	72066018C02001
Implementing Partner(s):	Abt Associates
Tracking ID:	
Tracking ID/link of Related EMMP:	
Tracking ID/link of Related IEE:	DRC_Health_Portofolio_IEE: https://ecd.usaid.gov/repository/pdf/45611.pdf
Tracking ID/link of Other, Related Analyses:	

ORGANIZATIONAL/ADMINISTRATIVE DATA

Implementing Operating Unit(s): (e.g. Mission or Bureau or Office)	USAID/Democratic Republic of the Congo (USAID/DRC)
Lead BEO Bureau:	
Prepared by:	Peter Chandonait, Abt Associates Inc.
Date Prepared:	
Submitted by:	USAID's Integrated Health Program
Date Submitted:	October 30, 2018

ENVIRONMENTAL COMPLIANCE REVIEW DATA

Analysis Type:	EMMR
Additional Analyses/Reporting Required	

⁶ Due to a stop-work order, the Program did not start until May 26, 2018.

PURPOSE

Environmental Mitigation and Monitoring Reports (EMMRs) are required for USAID-funded projects when the 22CFR216 documentation governing the project impose conditions on at least one project/activity component. EMMRs ensure that the Automated Directives System (ADS) 204 requirements for reporting on environmental compliance are met. EMMRs are used to report on the status of mitigation and monitoring efforts in accordance with IEE requirements over the preceding project implementation period. They are typically provided annually, but the frequency will be stipulated in the IEE. Responsibility for developing the EMMRs lies with USAID, but EMMRs are usually prepared by the Implementing Partner (IP) and submitted to USAID.

SCOPE

The following EMMR documents the mitigation measures implemented as detailed in the project EMMP, challenges encountered, and corrective actions taken. It describes the status of each required mitigation measure as stipulated in the EMMP and provides a succinct update on progress regarding the implementation and monitoring of the Environmental Mitigation and Monitoring Plan (EMMP).

These are the intervention activities that we anticipate. Each of these activities received categorical exclusion and negative determination based on what this activity involves:

- Studies, surveys/public health surveillance, and other data-gathering assessments, models, and capacity-building in support of all areas above. Dissemination of resulting information/ lessons learned/ best practices.
- Healthcare provider training; healthcare workforce strengthening and development
- Direct and capacity-building support for health service delivery and access to health services, excluding commodity procurement/supply chain strengthening.
- Procurement, storage, management, distribution, and disposal of medical and pharmaceutical commodities.
- Social and behavior change communication
- Small-scale water supply and sanitation
- Construction other than water/sanitation infrastructure
- Technical support to indoor residual spraying (IRS)
- Policy and strategy development

Those activities that have negative determination with conditions activate the need for the EMMP. The EMMP elucidates impacts that may be expected from USAID IHP, and mitigation efforts to eliminate or minimize those potential impacts. During the life of the project, if activities are developed that include potential environmental impacts not anticipated here, the EMMP will be amended to address and mitigate them.

A major environmental concern about health projects such as USAID IHP is the proper disposition of wastes generated from health facilities. These wastes include:

- General healthcare waste, which is similar or identical to domestic waste, including materials such as packaging or unwanted paper. This waste is generally harmless and needs no special handling; 75–90% of waste generated by healthcare facilities falls into this category.
- Hazardous healthcare waste, which includes infectious waste (except sharps and waste from patients with highly infectious diseases), small quantities of chemicals and pharmaceuticals, and non-recyclable pressurized containers.
- Highly hazardous healthcare waste, which includes sharps, highly infectious non-sharp waste, stools from cholera patients, bodily fluids of patients with highly infectious diseases, large

quantities of expired or unwanted pharmaceuticals and hazardous chemicals and radioactive wastes, genotoxic wastes (affecting genetic composition and multiple generations), or teratogenic wastes (affecting development of the exposed individual) (<http://www.usaidgems.org/Sectors/healthcareWaste.htm>)

Particularly in developing countries, it can be difficult to identify facilities for proper disposal, and sensitivity of the need for proper disposal is often lacking.

Storing pharmaceutical and medical commodities poses challenges as well, particularly special storage temperature requirements and expiration dates. Over-ordering or an unexpected reduction in demand can each result in expired pharmaceuticals that must be properly disposed of. Care must be taken to ensure security during storage of pharmaceuticals and commodities, to guard against losses and improper usage. Pharmaceuticals must be protected from contamination from incompatible materials stored in close proximity to them.

Sub-grant activities can cover a wide range of interventions and the environmental compliance requirements will vary accordingly. Environmental Review Forms (ERF) must be completed to gauge the potential environmental impacts of the contemplated activities under the grant and to develop mitigation strategies and plans. Due diligence must be performed on the grantee to confirm that they have the institutional knowledge, capacity, and will to perform within environmental compliance standards. Training must be provided and ongoing monitoring and inspection will likely be necessary.

Much like the sub-grant activities discussed above, funding the acquisition of medical equipment for use by others can carry a broad set of concerns, including misuse and improper disposal. Care must be taken to perform due diligence to confirm the acquiring institution has the ability to use the equipment correctly and safely, receives the required training, and has the orientation and commitment to dispose of it properly.

Another major concern that could arise from USAID IHP involves the small-scale construction and/or rehabilitation of existing facilities. Risks include construction methods that lead to contaminated runoff entering water resources; demolition of facilities containing hazardous substances, such as asbestos or lead piping; increased traffic from upgraded facilities leading to environmental degradation; and increased demand for WASH infrastructure, leading to environmental contamination if such facilities are not well-planned. There are distinct guidelines and requirements for rehabilitation of facilities delivering health care services, serving as diagnostic laboratories, or providing practical or lab-based health training, and for other types of buildings. Both types are represented and dealt with in the Environmental Mitigation and Monitoring Plan.

The construction of water and sanitation systems is also contemplated under this project; such work has an extensive set of requirements to ensure the supply of sufficient water quantity and quality without compromising existing uses of source water. Proper location of facilities, use of appropriate materials, methods of purification, and maintenance of equipment must also be taken into consideration. Trainings on system operation and maintenance must also be provided.

Insecticide-treated nets generate waste streams upon initial distribution and disposal. This waste must be managed according to WHO best practices to avoid negative impacts on the environment—and possibly on human health.

Office management and supply can also have negative impacts on the physical and social environment. Low-energy lighting and equipment must be preferentially purchased, and waste minimization and disposal must be planned and executed. Transportation of personnel and supplies must be carefully coordinated to minimize fuel usage and emissions.

[Customizable by Bureau: The EMMR may be linked to incremental funding actions.]

USAID REVIEW OF EMMR

[The routing process and associated signature blocks may be customized by Bureau or Mission. Please follow Bureau- or Mission-specific guidance. Include signature blocks in accordance with Bureau and/or Mission policy. At a minimum include the noted required signatures. Add other signatures as necessary.]

Approval:

[NAME], Activity Manager/A/COR [required]	Date

Clearance:

[NAME], Mission Environmental Officer [as appropriate]	Date

Clearance:

[NAME], Regional Environmental Advisor [as appropriate]	Date

Concurrence:

[NAME], _____ Bureau Environmental Officer [as required]	Date

DISTRIBUTION: *[Distribution lists may be customized by Bureau or Mission. Please follow Bureau- or Mission-specific guidance.]*

I.0 PROJECT/ACTIVITY SUMMARY

The implementation of USAID IHP is subject to the requirements of the USAID/DRC Health Office Portfolio Initial Environmental Examination (IEE) (USAID, July 2015), which examined the proposed activities of the entire Portfolio, and assigned to each activity a threshold determination. These determinations include Categorical Exclusion, indicating no expected environmental impact; Negative Determination with Conditions, signifying that possible environmental impacts can be mitigated by use of particular methods or actions; and Positive Determination (likely to have an impact on the environment). Please see table below for results.

Intervention Category	Categorical Exclusion(s)	Negative Determination(s)	Positive Determination(s)
1. Studies, surveys/public health surveillance, and other data-gathering assessments, models, and capacity-building in support of all areas above. Dissemination of resulting information/ lessons learned/ best practices.	X	X	
2. Healthcare provider training; healthcare workforce strengthening and development	X	X	
3. Direct and capacity-building support for health service delivery and access to health services, excluding commodity procurement/supply chain strengthening.	X	X	
4. Procurement, storage, management, distribution, and disposal of medical and pharmaceutical commodities.	X	X	
5. Social and behavior change communication	X		
6. Small-scale water supply and sanitation	X	X	
7. Construction other than water/sanitation infrastructure	X	X	
8. Technical support to indoor residual spraying (IRS)		X	X
9. Policy and strategy development	X	X	

Based on these interventions, which are all expected to be executed under USAID IHP, Abt intuited the specific activities that would be required in order to accomplish the objectives of the interventions. We then developed a list of potential environmental impacts that could be expected from these activities. Finally, an Environmental Mitigation and Monitoring Plan was developed in order to eliminate or mitigate to the extent practical the potential environmental impacts from the activities.

Although the project has not yet implemented these interventions, we have developed the framework of the Environmental Mitigation and Monitoring report that will be used over the life of the project (edited or adapted as needed) to report on the status of the mitigation measures, including any outstanding issues.

2.0 INSTRUCTIONS

No Bureau-specific EMMR requirements have been communicated.

3.0 MANAGEMENT STRUCTURE FOR ENVIRONMENTAL COMPLIANCE

The following response relates to the USAID IHP project staffing and management structure for environmental compliance:

USAID IHP will not have a dedicated position for an Environmental Compliance Officer. Two staff members, the Director of Service Delivery and the HSS Advisor, will be assigned the additional duties and responsibilities to ensure environmental compliance as it pertains to the EMMP and CRMP. The Director of Service Delivery and HSS Advisor will report on environmental compliance activities to the DCOP. The COP has reporting responsibility to USAID.

4.0 MONITORING AND REPORTING FOR ENVIRONMENTAL COMPLIANCE

As per Africa and Global Health Bureau-approved Environmental Mitigation and Monitoring Plan.

5.0 EMMR TABLE FOR USAID IHP

Project/Activity/Sub-Activity	Status of Mitigation Measures	Outstanding Issues Relating to Required Conditions	Remark
Education, technical assistance, training, to improve access to and delivery of health care.	Still in planning phase for implementation		Not started yet
Procurement, storage and management of public health commodities, including pharmaceuticals and supply chain strengthening activity	Still in planning phase for implementation		Not started yet
Funding private sector acquisition of diagnostic and treatment equipment	Still in planning phase for implementation		Not started yet
Very small-scale construction or rehabilitation (less than 1000m ² total disturbed area) with no complicating factors.	Still in planning phase for implementation		Not started yet
Small Scale Construction	Still in planning phase for implementation		Not started yet
Provision of long-lasting insecticidal nets (LLINs) for vector control	Still in planning phase for implementation		Not started yet
Sub-grant activities	Still in planning phase for implementation		Not started yet
Construction and improvement of water and sanitation systems	Still in planning phase for implementation		Not started yet
Office management and supply	Still in planning phase for implementation		Not started yet
Transportation of personnel and supplies	Still in planning phase for implementation		Not started yet
[Add / remove rows as needed]			

ADDITIONAL COMMENTS

Add comments as needed

6.0 ATTACHMENTS